Special Care Dentistry Referral Pro-forma

Belfast Health and Social Care Trust

All referrals are reviewed by a Consultant in Special Care Dentistry. Inappropriate or incomplete referrals will be returned outlining the reason(s) for return. **Please complete pages 1 – 3.**

The responsibility for ongoing dental care during the course of this referral remains with the referring dental professional.

1. PATIENT DETAILS		**Referral date**
Title	Surname	Forename
Address Post Code		
Date of Birth		
Telephone No.	Mobile No.	
H&C No.		
2. NEXT OF KIN / MAIN CARER /GUARDIAN DETAILS		
Relationship to the patient:		
Title	Surname	Forename
Address Post Code		
Telephone No.	Mobile No.	
Care Worker Name (if applicable)		Telephone No.

3. GENERAL MEDICAL PRACTITIONER		**Dental Hospital Rec Date STAMP**
Name		
Cypher No.		
Address Post Code		
Telephone No.	Mobile	

4. Please select the <u>specific reason(s)</u> for referral of this patient to Special Care Dentistry

The patient has a learning disability / cognitive impairment and is not suitable for Community Dental Service (CDS) dental care	
The patient has a physical disability or neurological impairment and is not suitable for CDS dental care	
The patient has challenging behavior which makes care in a General Dental Practice (GDP) or CDS setting not possible.	
The patient has a significant mental health problem which makes care in a GDP or CDS setting not possible.	
The patient has a medical condition that increase the risk of dental treatment complications – please outline;	
Other- please outline;	

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5. MEDICAL HISTORY / MEDICATIONS / KNOWN ALLERGIES DETAILS – completion is mandatory	
Relevant Medical History →	No relevant medical history ☐
List all current medications The patient is **not** taking any medications currently ☐	
Is the patient currently taking or has the patient ever taken Bisphosphonate Therapy Yes ☐ No ☐ If yes please give details of treatment and outline if treatment was Oral or Intravenous.	
Please list any known allergies;	No known allergies ☐

6. DENTAL REQUIREMENTS AND DENTAL HISTORY
What dental treatment does the patient need?
What dental treatments have you attempted to provide and what difficulties were encountered?

7. RADIOLOGY						
Are X-Rays being forwarded	Yes				X-Ray Not available	
The X-Rays being forwarded are	IOPA		Bitewings		OPTs	

8. Referral categorisation by referring professional please select one of the three options		
☐	REG FLAG	A red flag referral is only for cases of suspected cancer. Please give details; Patient is seen within 2 weeks.
☐	Urgent	Urgent cases are non-cancerous, Please give details;
☐	Routine	Routine cases are added to the routine waiting list for Special Care Dentistry

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9. Patient Access		
Is there any doubt about the patients capacity to consent	Yes	No
Where necessary has the responsible person provided consent for this referral?	Yes	No
Is the patient a wheelchair user?	Yes	No
Is the patient able to weightbear to transfer to a dental chair?	Yes	No
If no, is a hoist required for transfer to a dental chair?	Yes	No
Is an interpreter required?	Yes	Language

Please indicate the type of transportation this patient will require to attend the School of Dentistry		
Ambulance ☐	Wheelchair Taxi ☐	Has own private transport ☐

10. REFERRING PROFESSIONALS DETAILS	
Name	
Practice Address	
Post Code	
Telephone No.	
Email address	
I confirm that this referral meets the criterial for referral to Special Care Dentistry as outlined by the Belfast Trust ☐	
As referring professional please indicate the professional group to which you belong; GDP ☐ CDS dentist ☐ Dental Consultant ☐ Other ☐	

Please forward this referral to;

Central Dental Appointments Office,
2nd Floor, School of Dentistry
Grosvenor Road
Belfast BT12 6BA

Email to **SODReferrals@belfasttrust.hscni.net**