East Sussex Healthcare NHS Trust

East Sussex Special Care Dental Service

Patient Referral form

REFERRER DETAILS	
Referrer Name	
Healthcare Professional Role	**GMP** ☐ **Other** (Mandatory (please specify) ☐
Address	
Postcode	
Telephone Number	
Email Address	
Name of GP (if not detailed above)	
GP Address	

PATIENT DETAILS	
Title	☐ **Gender** (please specify) ☐
Surname	
Forename	
Date of Birth	/ / **NHS Number** ☐
Address	
Postcode	
Telephone Number	Home: Mobile:
Email address	
Name of Parent/Guardian/ Carer	
Name and relationship of Lasting Power of Attorney/ Next of Kin	Name: Relationship: Contact details:

Full medical history

(Patient Record Summary preferable)

Medication:

Exempt from dental charges	Yes ☐ **Mandatory** (please state exemption)_____ No ☐ Unknown ☐

Referral Criteria– please tick relevant box

☐ Learning Disability (please give details below)	☐ Children on child protection plan or from homeless families
☐ Autistic Spectrum Disorders (please give details below)	☐ Travellers children
☐ Severe physical disabilities (please give details below)	☐ Significant social problems
☐ Complex/severe mental illness (please give details below to support severity threshold)	☐ Adults and children with learning disability who require treatment under general anaesthetic
☐ Complex medical history/disabilities (please give details below to support severity threshold)	☐ Children who require extractions under general anaesthetic due to a young age or children requiring multiple extractions.

What additional needs does the patient have that requires special care dentistry?

Domiciliary Care

Does the patient attend any other appointments ☐ If yes, how do they get to them?

Does the patient leave the home for any other reasons ☐

Please explain why the patient is housebound:

Dental Care Needs/ Dental History – please detail any significant dental history or care received:

I confirm that I have advised the patient that:

- If patient contact details change these must be updated by the patient through the referrer to the service.
- The Special Care Dental Service will assess if the patient meets the referral criteria.
- Not all patients will remain under the care of the service.
- If a patient fails to attend they may be discharged.

Name (referrer)	
Date	

Dental Office use only
Date referral received :
Accepted ☐ **Does not meet criteria** ☐
Priority
1 ☐ 2 ☐ 3 ☐
Location
IG ☐ ABC ☐ UCK ☐ SF ☐

A	☐ Learning disability
B	☐ Autistic
C	☐ Severe physical disability
D	☐ Severe and enduring mental illness
E	☐ Domiciliary care
F	☐ Social issues
G	☐ Complex medical history/disability
H	☐ GA referral