Send completed forms via ERS. Enquiries: [esht.communitydentalservice@nhs.net](mailto:esht.communitydentalservice@nhs.net) or 0300 131 4542.

Our Special Care Dental Service (SCDS) provides treatment to adults and children who require special care dentistry. NHS dental charges apply to all patients unless they meet NHS dental exemption criteria and can supply evidence of this exemption.

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer Details** | | | |
| **Referrer Name** |  | | |
| **Role** | General Medical Practitioner  Other – specify: | | |
| **Address** |  | | |
| **Phone** |  | | |
| **Email** |  | | |
| **GP** |  | | |
| **GP Address** |  | | |
| **Patient Details** | | | |
| **Title** |  | **Sex** |  |
| **Name** |  | | |
| **Date of Birth** |  | **NHS No** |  |
| **Address** |  | | |
| **Phone** |  | | |
| **Email** |  | | |
| **Name of Parent/ /Carer** | Name: Relationship:  Contact details: | | |
| **Lasting Power of Attorney/ Next of Kin** | Name: Relationship:  Contact details: | | |
| **Reason for Referral** | | | |
| **Full medical history**  *Patient summary attached at end of document* | | | |
| **Medication**  *List attached at end of document* | | | |
| **Is the patient exempt from dental charges?**  Yes – State exemption reason:  No  Unknown | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Referral & Eligibility 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 (children only) | |
|  | 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?  No Yes \*  \* If yes, how do they get to them?  Does the patient leave the home for any other reasons? Yes  No \*  \* If no, please explain why the patient is housebound: | | | | | | |
| **Dental Care Needs/ Dental History** – please detail any significant dental history or care received: | | | | | | |
| **Referral Declaration** | | | | | | |
| 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. | | | | | | |
| **Referred by** | |  | | | **Date** |  |
|  | | | | | | |
| **Dental Office Use Only** | | | | A | Learning disability | |
| Date referral received: | | | | B | Autistic | |
| Accepted | | | Does not meet criteria | C | Severe physical disability | |
| **Priority** | | | | D | Severe and enduring mental illness | |
| 1  2  3  4 | | | | E | Domiciliary care | |
| Location | | | | F | Social issues (children only) | |
| IG  ABC  UCK  SF | | | | G | Complex medical history/disability | |
|  | | |  | H | GA referral | |

[Allergies]

[Medications]

[Problem list]