

# PAEDIATRIC DENTISTRY REFERRAL FORM (CHILDREN 15 YEARS OLD AND YOUNGER)

<b>Surname:</b>	<b>First Name(s):</b>	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to say
<b>Date of Birth:</b>	<b>NHS Number:</b> (If known)	Is this referral urgent? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Home Address:</b>		<b>PREFERRED INFORMATION</b>
		<b>GP Name :</b> <b>GP Address:</b>
<b>Post Code:</b>	<b>Borough:</b>	<b>Post Code:</b>
<b>Phone:</b>		<b>Borough:</b>
<b>Mobile contact:</b>		<b>Phone:</b>
<b>BSL Interpreter Required?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Which language?</b>
<b>Medical History</b> (attach additional information as required)		<b>List all Medication</b> (attach additional information as required)
<b>Please record here any mobility / transport issues:</b>		
<b>Dental History</b> <b>1. Attendance:</b> Is this child? <input type="checkbox"/> A regular attender <input type="checkbox"/> Occasional, in trouble attender <input type="checkbox"/> Never been before <b>3. In the last 3 years have any other children in the family had teeth out because of decay:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>5. Toothbrushing and sugar in the diet:</b> Who usually brushes the child's teeth at bedtime? <input type="checkbox"/> The child <input type="checkbox"/> An adult <b>7. Does the child usually have a sweet drink at bedtime?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>2. Dental pain and antibiotics:</b> Over the last week, has the child had toothache? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>4. Over the last 3 months, has the child had antibiotics for tooth problems?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>6. Preventive advice that has been given, prior to referral:</b> Toothbrushing at bedtime and one other time with fluoride toothpaste with at least 1,000 ppm Fluoride <input type="checkbox"/> Yes <input type="checkbox"/> No <b>8. Dietary advice to reduce free sugars in food and drinks</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Dental treatment provided, tick ALL relevant boxes:</b>		

- |                                                                       |                                                              |
|-----------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Fluoride varnish applied                     | <input type="checkbox"/> Failed attempt at local anaesthesia |
| <input type="checkbox"/> Fissure sealants applied to permanent molars | <input type="checkbox"/> Behaviour management                |
| <input type="checkbox"/> Temporary fillings                           | <input type="checkbox"/> Any other treatment?                |
| <input type="checkbox"/> No treatment attempted                       | <input type="checkbox"/> Unable to treat (specify reason)    |

### How does the above patient meet the Paediatric Dentistry Referral criteria?

- |                                                                                                              |                                                                                                |                                                                                             |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Dental Caries – Pre co-operative (under 6)                                          | <input type="checkbox"/> Dental Anomalies – altered tooth structure, number, shape, size, form | <input type="checkbox"/> Surgical management e.g. unerupted teeth/ broken down teeth        |
| <input type="checkbox"/> Dental caries – Over 6 years (expand under history why referral should be accepted) | <input type="checkbox"/> Periodontal (gum) problems                                            | <input type="checkbox"/> Complex medical problems – expand below                            |
| <input type="checkbox"/> Dental trauma - Primary and permanent. (expand under history)                       | <input type="checkbox"/> Soft Tissue Conditions – mucocoeles/ ulcers                           | <input type="checkbox"/> Complex behavioural problems unsuitable for General Practice       |
| <input type="checkbox"/> Opinion about poor quality first permanent molars. No RCT.                          | <input type="checkbox"/> Disorders of tooth eruption and loss                                  | <input type="checkbox"/> Children in the care of social services e.g. Looked after children |
| <input type="checkbox"/> Tooth surface loss – e.g. erosion                                                   |                                                                                                |                                                                                             |

### Additional History:

### What has been explained to parents/guardian?

- ☐ Behaviour management
- ☐ Local anaesthesia
- ☐ Inhalation sedation
- ☐ Intravenous sedation
- ☐ General anaesthesia

### Radiographs:

- ☐ Not possible
- ☐ Enclosed
- ☐ Sent digitally

### Name of Referrer

### Date of referral

### Job Title:

### Organisation:

### Date Received (office use)

### Address:

### Post Code:

### Phone / Mobile

### Secure Email:

**THIS REFERRAL WILL NOT BE ACCEPTED WITHOUT COMPLETION OF ALL SECTIONS. ON COMPLETION PLEASE SEND THE REFERRAL FORM TO RELEVANT CDS PROVIDER**

## REFERRAL / TRIAGE OUTCOME

(For completion by CDS provider)

<b>Date Referral Received:</b>	/   /	
<b>Date of Referral Triage:</b>	/   /	
<b>Triage undertaken by:</b>	<b>Name</b>	<b>Job Title</b>
<b>OUTCOME OF REFERRAL</b>		
<b>ACCEPTED</b>	<input type="checkbox"/>	
Suggested Provider:		
Level I (Training and Education)	<input type="checkbox"/>	
Level II (CDS)	<input type="checkbox"/>	
Level III (Acute Care)	<input type="checkbox"/>	
<b>DECLINED</b>	<input type="checkbox"/>	
Reasons		
1. Insufficient Information with regards to:	<input type="checkbox"/> Patient details	
	<input type="checkbox"/> Reasons for the referral	
2. Radiographs	<input type="checkbox"/> Absent when stated enclosed / electronically transmitted	
3. Inappropriate level of patient complexity to specific unit	<input type="checkbox"/> No evidence that complexity of referral is appropriate to a Level II service	
	<input type="checkbox"/> No evidence that complexity of referral is appropriate to a Level III service (try a Level II service)	