NHS England

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

Surname:	**First Name(s):**	**Gender:** ❑ Male ❑ Female ❑ Prefer not to say
Date of Birth:	**NHS Number:** (If known)	Is this referral urgent? ❑ Yes ❑ No

Home Address: **Post Code:** **Borough:** **Phone:** **Mobile contact:**	**PREFERRED INFORMATION** **GP Name :** **GP Address:** **Post Code:** **Borough:** **Phone:**

BSL Interpreter Required? ❑ Yes ❑ No

Which language?

Medical History (attach additional information as required) **Please record here any mobility / transport issues:**	**List all Medication** (attach additional information as required)

Dental History

1. Attendance:
Is this child?
- ❑ A regular attender
- ❑ Occasional, in trouble attender
- ❑ Never been before

2. Dental pain and antibiotics:
Over the last week, has the child had toothache?
- ❑ Yes
- ❑ No

3. In the last 3 years have any other children in the family had teeth out because of decay:
- ❑ Yes
- ❑ No

4. Over the last 3 months, has the child had antibiotics for tooth problems?
- ❑ Yes
- ❑ No

5. Toothbrushing and sugar in the diet:
Who usually brushes the child's teeth at bedtime?
- ❑ The child
- ❑ An adult

6. Preventive advice that has been given, prior to referral:
Toothbrushing at bedtime and one other time with fluoride toothpaste with at least 1,000 ppm Fluoride
- ❑ Yes
- ❑ No

7. Does the child usually have a sweet drink at bedtime?
- ❑ Yes
- ❑ No

8. Dietary advice to reduce free sugars in food and drinks
- ❑ Yes
- ❑ No

Dental treatment provided, tick ALL relevant boxes:

- ❑ Fluoride varnish applied
- ❑ Fissure sealants applied to permanent molars
- ❑ Temporary fillings
- ❑ No treatment attempted
- ❑ Failed attempt at local anaesthesia
- ❑ Behaviour management
- ❑ Any other treatment?
- ❑ Unable to treat (specify reason)

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

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

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 <u>WILL NOT</u> 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)

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