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:**	**GP Name :** **GP Address:** **Post Code:** **Borough:** **Phone:**
Interpreter Required? ❑ Yes ❑ No	**Which language?** ..... **BSL** ☐

Medical History, Disability Is patient under hospital care for a medical reason? **Y / N** If yes, which hospital:	**Medication**

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

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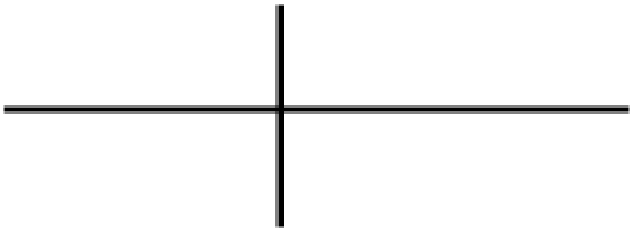
- ❑ Dental Caries : likely GA (provide details below)
- ❑ Dental caries – other : (expand below why referral should be accepted)
- ❑ Dental trauma - Primary and permanent. (expand under history)
- ❑ Opinion about poor quality first permanent molars (not RCT)
  NB Consider obtaining ortho opinion first
- ❑ Complex medical or behavioural problems (*expand below)*
- ❑ Tooth surface loss – e.g. erosion
- ❑ Dental Anomalies – altered tooth structure, number, shape, size, form
- ❑ Disorders of tooth eruption and loss
- ❑ Surgical management e.g. un-erupted teeth
- ❑ Periodontal problems
- ❑ Soft Tissue Conditions
- ❑ This is Level 1 and appropriate for training purposes
- ❑ NB are there Safeguarding concerns or is child in the care of social services e.g. Looked after children. Please provide more details below.

Why are you referring this patient? Include a charting of treatment needed with an indication of urgency and/or severity such as recent pain or antibiotic use

NB A failure to provide sufficient and legible information here may lead to rejection of this referral

Give an indication of urgency :

Chart treatment needed :



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Dental treatment you have provided, tick relevant boxes (*expand above or below***) :**

❑ Prevention including Fluoride Varnish

❑ Restorations temp □ permanent □

❑ Radiographs (*attach if available*)

❑ Other e.g. Hall crowns

❑ Attempted local anaesthesia

❑ Unable to treat further (*expand above*)

…… ……

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