Hertfordshire Community NHS
NHS Trust

SPECIAL CARE DENTAL SERVICE

Patient Referral Form – for use by ***Health Care Workers***

Patients of any age with special needs who meet the service acceptance criteria will be considered. All sections of this form must be fully completed to avoid unnecessary delays and incomplete forms will be returned. An electronic version is available on request.

Once completed please send this form to :
Clinical Director, Special Care Dental Service, Unit 10 Sandridge Gate Business Centre, Ronsons Way St Albans AL4 9XR Tel: 01727 732052 Email: hct.hertsdentaladmin@nhs.net

SECTION 1 – Acceptance Criteria

The patient being referred is a Hertfordshire resident who : *please tick*

- ☐ Is a wheelchair user unable to transfer to the dental chair without the use of a hoist
- ☐ Has a diagnosed moderate/severe learning disability who cannot be managed in General Dental Practice
- ☐ Has a diagnosed moderate/severe mental health problem who cannot be managed in General Dental Practice
- ☐ Has a complex medical condition not manageable in General Dental Practice

Please give details *:*

SECTION 2 – Patient details

Title	First name		Surname	
Patient identifies as	Male	Female	Non-binary	Prefers not to say
Date of Birth	NHS number			
Address				Post Code
Daytime Tel No.	Mobile Tel No.			

Does this patient need an interpreter ? YES NO

If ‘Yes’ which language would be required :

SECTION 3 – Treatment detail

Please give details of treatment requested

Does this patient have any of their own teeth ? ***Yes*** ***No***

Is this patient in unmanageable pain ?	**_Yes_**		**_No_**	
Has the patient ever displayed any aggressive behaviour ?	**_Yes_**		**_No_**	
If yes, please give details e.g. known triggers				
Has the patient seen their own General Dental Practitioner within the last year ?	**_Yes_**		**_No_**	
If yes, please give name of dentist(s) and address/telephone number				

REFERRING HEALTH CARE WORKER'S NAME & CONTACT DETAILS	
Name (Please print)	
Address	
Job Title	Tel. No.
Signature	Date

PATIENT/PARENT/LEGAL GUARDIAN *Please delete as appropriate:*

1. I would be happy to accept an appointment at the clinic with the shortest waiting time
2. I would prefer to wait for an appointment at the clinic closest to my home

I confirm that I understand and agree with the reasons for this referral.

Signature ___________________________________ Date

Relationship to patient ________________________Print Name___________________________

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TRIAGE OUTCOME (*for SCDS use*)

Date

Patient accepted for treatment	
Patient does not meet any of the criteria for this service	
Consider redirection of referral to MOS service	
Consider redirection to a sedation practice	
Incomplete referral form	
Comments	