

Paediatric Dental Department Referral Pro-forma

All referrers are requested to provide the information required on Pages 1 – 3 of this pro forma.
Inappropriate or incomplete referrals will be returned outlining the reason(s) for the return.

1. PATIENT DETAILS			Referral date			
Title	Surname	Forename	M / F	Date of Birth	Age	Interpreter required Yes / No
Address			Mobile no			
Post code			Telephone no			
			H&C no			
Has the person with parental responsibility provided consent for this referral? Yes / No						
If patient is attending with a care worker or guardian, please provide details:						
Name			Contact number			
Address (if different to above):						

2. REFERRING DENTIST	<input type="checkbox"/> GDP	<input type="checkbox"/> CDO / SDO
GDP name	CDO/SDO name	
Practice address	CDS Clinic address	
Postcode	Postcode	
Email address	Email address	
Telephone no	Telephone no	

3. REASON FOR REFERRAL																								
Please indicate the specific reason for the referral of this patient to the Paediatric Dental Department by selecting one or more from the referral criteria below:																								
Treatment under General Anaesthetic (GA) (select referral reason from list below) <input type="checkbox"/>																								
Please confirm as the referring dentist by answering YES that all possible alternative options for treatment provision, pain relief and anxiety management, along with the risks involved with GA, have been discussed with this patient / parent / guardian prior to making this referral. This referral will not be accepted for GA treatment without a YES answer being provided here. YES <input type="checkbox"/>																								
<table border="0"> <tr> <td><input type="checkbox"/> CARIES</td> <td><input type="checkbox"/> NON CARIOUS TOOTH SURFACE LOSS</td> </tr> <tr> <td><input type="checkbox"/> PAIN</td> <td><input type="checkbox"/> ENAMEL/DENTINE DEFECTS</td> </tr> <tr> <td><input type="checkbox"/> INFECTION</td> <td><input type="checkbox"/> DENTAL ANOMALIES</td> </tr> <tr> <td><input type="checkbox"/> SWELLING</td> <td><input type="checkbox"/> HYPODONTIA</td> </tr> <tr> <td><input type="checkbox"/> MULTIPLE EXTRACTIONS (<3YS OLD)</td> <td><input type="checkbox"/> SUPERNUMERARIES</td> </tr> <tr> <td><input type="checkbox"/> MULTIPLE EXTRACTIONS (COMPLICATING PMH)</td> <td><input type="checkbox"/> DISORDERS OF ERUPTION / EXFOLIATION</td> </tr> <tr> <td><input type="checkbox"/> BEHAVIOURAL ISSUES</td> <td><input type="checkbox"/> COMPLEX EXTNS (PROVIDE DETAILS & RADIOGRAPHS)</td> </tr> <tr> <td><input type="checkbox"/> LEARNING DISABILITY</td> <td><input type="checkbox"/> HARD TISSUE PATHOLOGY</td> </tr> <tr> <td><input type="checkbox"/> PROMINENT GAG REFEX</td> <td><input type="checkbox"/> SOFT TISSUE PATHOLOGY</td> </tr> <tr> <td><input type="checkbox"/> DENTOALVEOLAR TRAUMA</td> <td><input type="checkbox"/> TMJ RELATED ISSUES</td> </tr> <tr> <td><input type="checkbox"/> COMPLEX ENDODONTICS (OPEN APEX)</td> <td><input type="checkbox"/> PARAFUNCTIONAL HABITS</td> </tr> <tr> <td><input type="checkbox"/> OTHER</td> <td></td> </tr> </table>	<input type="checkbox"/> CARIES	<input type="checkbox"/> NON CARIOUS TOOTH SURFACE LOSS	<input type="checkbox"/> PAIN	<input type="checkbox"/> ENAMEL/DENTINE DEFECTS	<input type="checkbox"/> INFECTION	<input type="checkbox"/> DENTAL ANOMALIES	<input type="checkbox"/> SWELLING	<input type="checkbox"/> HYPODONTIA	<input type="checkbox"/> MULTIPLE EXTRACTIONS (<3YS OLD)	<input type="checkbox"/> SUPERNUMERARIES	<input type="checkbox"/> MULTIPLE EXTRACTIONS (COMPLICATING PMH)	<input type="checkbox"/> DISORDERS OF ERUPTION / EXFOLIATION	<input type="checkbox"/> BEHAVIOURAL ISSUES	<input type="checkbox"/> COMPLEX EXTNS (PROVIDE DETAILS & RADIOGRAPHS)	<input type="checkbox"/> LEARNING DISABILITY	<input type="checkbox"/> HARD TISSUE PATHOLOGY	<input type="checkbox"/> PROMINENT GAG REFEX	<input type="checkbox"/> SOFT TISSUE PATHOLOGY	<input type="checkbox"/> DENTOALVEOLAR TRAUMA	<input type="checkbox"/> TMJ RELATED ISSUES	<input type="checkbox"/> COMPLEX ENDODONTICS (OPEN APEX)	<input type="checkbox"/> PARAFUNCTIONAL HABITS	<input type="checkbox"/> OTHER	
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Please indicate the treatment required on the dental chart below

X for the teeth / roots to be **extracted**
R for teeth to be **restored**
E for **endodontics**

PERMANENT DENTITION

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

PRIMARY DENTITION

E	D	C	B	A	A	B	C	D	E
E	D	C	B	A	A	B	C	D	E

Summary of treatment being requested and any other relevant clinical information

Please describe previous dental history including experience with LA

Please state what attempts have been made to treat the child in primary care.

Has the patient been prescribed antibiotics in the past 3 months? Yes / No
 Antibiotic name(s)

Please indicate a referral grading Routine / Urgent
 Please outline reason for urgent referrals:

Have radiographs been included? Yes / No IOPA(s) Bitewings OPT

If radiographs are not included for referrals for tooth/hard tissue pathology/anomalies, including caries, please outline reason(s)

Please confirm by answering YES that preventive advice and continuing care will be offered to the patient irrespective of the referral.

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This referral will not be accepted without a YES answer being provided here. YES

4. MEDICAL HISTORY DO NOT SEND A BLANK FORM – STATE NONE IF NECESSARY

GP Name	Telephone no	Cypher No.
GP Address		
Postcode		

Please indicate if the patient has/has had/ suffers from

- | | |
|---|---|
| <input type="checkbox"/> NONE OF THE BELOW | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> HEART MURMUR NOT DIAGNOSED AS INNOCENT | <input type="checkbox"/> FAINTS |
| <input type="checkbox"/> CONGENITAL HEART DEFECT | <input type="checkbox"/> NEUROMUSCULAR DISORDER |
| <input type="checkbox"/> ASTHMA / BRONCHITIS / CHEST COMPLAINT | <input type="checkbox"/> SKIN PROBLEMS |
| <input type="checkbox"/> ENT PROBLEM | <input type="checkbox"/> MUSCULOSKELETAL DISORDER |
| <input type="checkbox"/> BLOOD OR BLEEDING PROBLEM | <input type="checkbox"/> OBESITY |
| <input type="checkbox"/> INFECTIOUS DISEASE (EG HEPATITIS) | <input type="checkbox"/> BEHAVIOURAL DISORDER |
| <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> AUTISM / ADHD |
| <input type="checkbox"/> KIDNEY PROBLEM | <input type="checkbox"/> LEARNING DISABILITY |
| <input type="checkbox"/> ANAEMIA | <input type="checkbox"/> VISUAL IMPAIRMENT |
| <input type="checkbox"/> ONCOLOGY DIAGNOSIS | <input type="checkbox"/> COMMUNICATION IMPAIRMENT |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> SYNDROME |
| <input type="checkbox"/> OTHER ENDOCRINE DISORDER | <input type="checkbox"/> ALLERGY (SEE BELOW) |
| <input type="checkbox"/> OTHER | |

Please provide details on any of the above, outlining the severity of the condition listed above and any possible impact on delivery of care

Please provide details of any known allergies	Please provide details of current prescribed medications
If currently or previously under hospital care, please state name of paediatrician and hospital attended	<p>Mobility issues</p> <input type="checkbox"/> Walks unaided <input type="checkbox"/> Walks aided <input type="checkbox"/> Wheelchair user <p>Language issues</p> Is an Interpreter required Yes <input type="checkbox"/> Specify Language _____

All referrals to Belfast Trust, Paediatric Dental Department can be posted or emailed.

Postal address:
Paediatric Dental Department,
Royal Belfast Hospital for Sick Children,

Paediatric Dental Department Referral Pro-forma

Falls Road
Belfast
BT12 6BA
Landline: 02890 632048

Email address: paedsdentalreferrals@belfasttrust.hscni.net