

Paediatric Dental Department Referral Pro-forma

1. PATIENT DETAILS

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.

Referral date

Title	Surname	Forename		M/F	Date of Birth	Age	Interpreter required Yes / No	
Address					Mobile no			
				Telephone no				
Post code				H&C no				
Has the person with parental responsibility provided con								
						100 / 10	0	
If patient is attending with a care worker or guardian, ple Name					Contact number			
	Cr. Programme (1)			Contac	t number			
Address (if different to above):								
2.	REFERRING DENTIS	т	☐ GDP		00 / SDO			
GDP name			CDO/SDO name					
Practice address			CDS Clinic address					
Destanda			Postcode					
Postcode Email address								
Email address			Email address					
Telephone no				Telephone no				
	DE 1001 FOR REFE							
	REASON FOR REFEI							
	-		ne referral of this	s patient	to the Paediatri	c Dental	Department by selecting one	
or more from the referral criteria below:								
Treatment under General Anaesthetic (GA) (select referral reason from list below)								
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.								
CARIES					NON CARIOUS TOOTH SURFACE LOSS			
PAIN	PAIN			ENAMEL/DENTINE DEFECTS				
INFE	INFECTION			☐ DENTAL ANOMALIES				
SWE	SWELLING			HYPODONTIA				
MULTIPLE EXTRACTIONS (<3YS OLD)			SUPERNUMERARIES					
MUL	MULTIPLE EXTRACTIONS (COMPLICATING PMH)			DISORDERS OF ERUPTION / EXFOLIATION				
ВЕН	BEHAVIOURAL ISSUES			COMPLEX EXTNS (PROVIDE DETAILS & RADIOGRAPHS)				
LEARNING DISABILITY			☐ HARD TISSUE PATHOLOGY					
PROMINENT GAG REFEX			SOFT TISSUE PATHOLOGY					
☐ DENTOALVEOLAR TRAUMA			☐ TMJ RELATED ISSUES					
COMPLEX ENDODONTICS (OPEN APEX)			F	PARAFUNCTIONAL	HABITS			
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 8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8 1 2 3 4 5 6 7 8							
PRIMARY DENTITION								
E D C B A E D C B A	A B C D E A B C D E							
Summary of treatment being requested and any other relevant clinical information								
•	Please state what attempts have been made to treat the child in primary care.							
months? Yes / No	Please indicate a referral grading Routine / Urgent							
Antibiotic name(s)	Please outline reason for urgent referrals:							
Have radiographs been included? Yes / No	IOPA(s)							
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.							



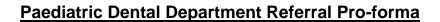


This referral will not be accepted without a YES answer being provided here.								
4. MEDICAL HISTORY DO NOT SEN	ID A BLANK FORM – STATE NONE IF NECESSARY							
GP Name Teleph	hone no Cypher No.							
GP Address	·							
Postcode								
Please indicate if the patient has/has had/ suffers from								
☐ NONE OF THE BELOW	☐ EPILEPSY							
HEART MURMUR NOT DIAGNOSED AS INNOCENT	FAINTS							
CONGENITAL HEART DEFECT	NEUROMUSCULAR DISORDER							
ASTHMA / BRONCHITIS / CHEST COMPLAINT	SKIN PROBLEMS							
ENT PROBLEM	MUSCULOSKELETAL DISORDER							
BLOOD OR BLEEDING PROBLEM	OBESITY							
INFECTIOUS DISEASE (EG HEPATITIS)	BEHAVIOURAL DISORDER							
LIVER DISEASE	AUTISM / ADHD							
KIDNEY PROBLEM	LEARNING DISABILITY							
ANAEMIA	☐ VISUAL IMPAIRMENT							
ONCOLOGY DIAGNOSIS	COMMUNICATION IMPAIRMENT							
DIABETES	SYNDROME							
OTHER ENDOCRINE DISORDER	ALLERGY (SEE BELOW)							
OTHER								
Please provide details on any of the above, outling	ning 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							
γ								
If currently or previously under hospital care, plea	ase state Mobility issues							
name of paediatrician and hospital attended	☐ Walks unaided							
	☐ Walks aided							
	☐ Wheelchair user							
	Language issues							
	Is an Interpreter required Yes							
	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,





Falls Road Belfast BT12 6BA

Landline: 02890 632048 Email address: paedsdentalreferrals@belfasttrust.hscni.net