**Referral to the Oral Health Service**

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| **pLEASE INDICATE THE SERVICE YOU ARE**  **REFERRING TO:** | | | | | | | | | | adult dental anxiety management | | | | | | | | | | | | | | | |  | | Paediatric dentistry | | | | | | | | | | | | | | |  |
| oral medicine | | | | | | | | | | | | | | | |  | | restorative dentistry | | | | | | | | | | | | | | |  |
| oral surgery | | | | | | | | | | | | | | | |  | | SCHOOL OF HYGIENE-THerapy | | | | | | | | | | | | | | |  |
| Referrals lacking details will be returned, resulting in delays. | | | | | | | | | | orthodontics | | | | | | | | | | | | | | | |  | | special care Dentistry | | | | | | | | | | | | | | |  |
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|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of referral:** | | | | | | | | | | | | | | | | | | | **Urgency of referral:** | | | | | | | | | | | | routine | | | | | | urgent | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PATIENT DETAILS:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TITLE | | | | |  | | | | | | | | | | | | | | | ADDRESS 1 | | | | |  | | | | | | | | | | | | | | | | | | |
| SURNAME | | | | |  | | | | | | | | | | | | | | | ADDRESS 2 | | | | |  | | | | | | | | | | | | | | | | | | |
| FORENAME(S) | | | | |  | | | | | | | | | | | | | | | TOWN | | | | |  | | | | | | | | | | | | | | | | | | |
| PREVIOUS SURNAME | | | | |  | | | | | | | | | | | | | | | POSTCODE | | | | |  | | | | | | | | | | | | | | | | | | |
| GENDER | | | | |  | | | | | | | | | | | | | | | TEL NUMBER | | | | | Home | | | | | | | | | | | Mobile | | | | | | | |
| DATE OF BIRTH | | | | |  | | | | | | | | | | | | | | | CHI NUMBER | | | | |  | | | | | | | | | | | | | | | | | | |
| ETHNICITY | | | | |  | | | | | | | | | | | | | | | I confirm the ‘Patient details’ are accurate | | | | | | | | | | | | | | | | | | | | | | | |
| **CONTACT DETAILS FOR APPOINTMENT:** | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT (as above) | | | | | | | OTHER: | | | | | | Name | | | | | | | | | | | | | | Relationship to patient | | | | | | | | | | | | | | | | |
|  | | | | | | |  | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient / Guardian / Proxy consents to the above receiving a copy of the appointment letter | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **REFERRER DETAILS:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TITLE | |  | | | | | | | | | | | | | | | | PRACTICE NAME | | | | |  | | | | | | | | | | | | | | | | | | | | |
| SURNAME | |  | | | | | | | | | | | | | | | | ADDRESS 1 | | | | |  | | | | | | | | | | | | | | | | | | | | |
| FORENAME | |  | | | | | | | | | | | | | | | | ADDRESS 2 | | | | |  | | | | | | | | | | | | | | | | | | | | |
| JOB TITLE | |  | | | | | | | | | | | | | | | | POSTCODE | | | | |  | | | | | | | | | | | | | | | | | | | | |
| LIST NUMBER | |  | | | | | | | | | | | | | | | | TEL NUMBER | | | | |  | | | | | | | | | | | | | | | | | | | | |
| **DENTAL PRACTITIONER DETAILS:** | | | | | | | | | | | | | **THIS IS THE REFERRER** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| NAME | | |  | | | | | | | | | | | | | | | | | | | | | TEL NUMBER | | | | | | | |  | | | | | | | | | | | |
| PRACTICE NAME | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ADDRESS | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICAL PRACTITIONER DETAILS:** | | | | | | | | | | | | | **THIS IS THE REFERRER** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| NAME | | |  | | | | | | | | | | | | | | | | | | | | | TEL NUMBER | | | | | | | |  | | | | | | | | | | | |
| PRACTICE NAME | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ADDRESS | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **SOCIAL WORKER:** | | | | YES | | | | | NO | | | | | | | NOT KNOWN | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Details if YES | NAME | | | | | | |  | | | | | | | | | | | | | | | | TEL NUMBER | | | | | | | |  | | | | | | | | | | | |
|  | ADDRESS | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NAME OF SCHOOL / NURSERY:** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | NOT APPLICABLE | | | | | | | |  | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **HISTORY OF PRESENTING COMPLAINT / EXAMINATION FINDINGS / INVESTIGATION RESULTS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  | | --- | --- | --- | | **BPE ≥7 yrs** | | | |  |  |  | |  |  |  | | | | | |
| **REASON FOR REFERRAL (INCLUDING DENTAL TREATMENT REQUEST):** (Please refer to the Service criteria on RefHelp) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DETAILS OF TREATMENT / INVESTIGATIONS ALREADY CARRIED OUT:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have relevant radiographs been taken? | | | | | | | | | | | | | | | | | Yes | | | | No | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RELEVANT MEDICAL HISTORY:** | | | | | | | | | | | IF NONE, PLEASE TICK | | | | | | | | | | | | | | | | | | | | | | **LIFESTYLE:** | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Alcohol units/week | | | | | | | | |  | |
| Smoking/day | | | | | | | | |  | |
| Ex- smoker (years) | | | | | | | | |  | |
| Other relevant lifestyle factors: | | | | | | | | | | |
| **CURRENT AND RECENT MEDICATION:** | | | | | | | | | | | | | | IF NONE, PLEASE TICK | | | | | | | | | | | | | | | **ALLERGIES:** | | | | | | IF NONE, PLEASE TICK | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ADDITIONAL RELEVANT INFORMATION:** (including patient issues, social circumstances and special needs) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IF NONE, PLEASE TICK | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Interpreter required in | | | | | | | | | | | | | |
|  | | | Hoist to dental chair required | | | | | | | | | | | | | |
|  | | | Requires ambulance transport | | | | | | | | | | | | | |
|  | | | Domiciliary care | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DECLARATION:** (This section must be completed in full or the referral may be returned) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relevant radiographs attached with Patient Identifiers (PIDs) as per ‘RefHelp’ guidelines. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | NO | | | N/A | | |
| Relevant radiographs with PIDs posted as per ‘RefHelp’ guidelines. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | NO | | | N/A | | |
| Study models forwarded by post. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | NO | | | N/A | | |
| Full periodontal charts attached for periodontal referrals. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | NO | | | N/A | | |
| Referral in keeping with SIGN and SDCEP guidelines. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | NO | | | N/A | | |
| For SoHT referrals: Patient consents to non-specialist directed, student therapist delivered treatment. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | NO | | | N/A | | |
| Patient advised that NHS fees may apply in accordance with the Statement of Dental Remuneration. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | YES | | | | NO | | | N/A | | |
| **Signature of referrer:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **Date:** | | | | | | | | |
| **For email** **referrals (preferred route):** This email represents my signature. I confirm that my **email address is secure and approved as safe to send ‘Patient Identifiable Information’** to [EDIreferrals@nhslothian.scot.nhs.uk](mailto:EDIreferrals@nhslothian.scot.nhs.uk)  **If you do not have a secure e-mail,** we will accept a paper referral**.** Please mark **‘Private and Confidential’** and send to Pathway Office, Duncan Street Dental Centre, 16 Duncan Street, Edinburgh, EH9 1SR. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |