**Referral to the Oral Health Service**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 | [ ]  |
|  |  |  |  |
|  |
| **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 [ ] **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. |