Derbyshire Community Health Services NHS
NHS Foundation Trust

Referral To Salaried Primary Care Dental Services

Please ensure this form is fully completed and legible or it will be returned.

Patient Name: _____ Title _____

Gender: Male ❑ Female ❑

Date of Birth: _____

Address: _____

_____ Post Code: _____

Tel No: _____

NHS No: _____ (if known)

Referrer Name: _____

Practice Name: _____

Job Title: _____

Address: _____

_____

_____ Post Code: _____

Tel No: _____

E Mail: _____

Is the patient exempt from NHS dental Charges: Yes ❑ No ❑

Reason For Referral (Please tick one of the following)

Child (Special Care) ❑
Medically Compromised ❑
Adult/Child with learning disability ❑
Adult Mental Health (under mental health care team) ❑
Child Behavioural/Anxiety (single course of treatment)
Either: Inhalation Sedation ❑
Or: GA ❑
Domiciliary Care ❑
IV Sedation (limited availability, Long Eaton site only) ❑

GP Name: _____

Address: _____

_____

_____

Post Code: _____

Tel No: _____

Reason why you believe this patient cannot be treated in general dental practice:

Previous dental history (including treatment with local anaesthetic, sedation, GA, hypnosis, treatment attempted etc).

Prevention/Acclimatisation ❑ Fillings without LA ❑ Fillings with LA ❑
Extraction with LA ❑ Treatment with RA/IV Sedation ❑ Previous referral to SPCDS ❑

Comments:

Treatment Requested:

To be restored: _____ To be extracted: _____

Radiographs sent ❑ Type _____

PTO

Medical history including details of current medication:

Special requirements to support delivery of dental care, eg hoist:

Is an interpreter required: Yes ❑ No ❑ (*The need for an interpreter will not be accepted as a sole reason for referral*)

Language required: _____

Referrer Declaration (Tick to indicate agreement)

- ❑ I have explained to the patient and/or parent/carer that I am referring them to the SPCDS for the reason/treatment detailed above.
- ❑ (For dentist referrals only) I have discussed alternative methods of treatment, ie LA/RA/GA and pain control.
- ❑ (For dentist referrals only) I have explained that the treatment provided on referral is a separate course of care and as such may incur further NHS charges where appropriate.
- ❑ The patient and/or parent/legal guardian has agreed to this referral.

Signature of Referrer: _____ Date: _____

Signature of Parent/Legal Guardian _____ Date: _____

The patient assessment will be based upon the information provided. This may mean that the patient will be asked to attend a clinic some distance from their home. Please could you advise them of this fact.
You are advised to keep a copy of this referral.

Completed forms should be sent to:-

- Referrals for children living in South Derbyshire should be sent to
  Mill Hill Dental Clinic, 2 Mill Hill Rd, Derby, DE23 6SF
- Referrals for adults living in South Derbyshire should be sent to
  Coleman Health Centre, Dental Department, Coleman Street, Alvaston, Derby, DE24 8NH
- Referrals for all patients living in North Derbyshire should be sent to
  Wheatbridge Dental, 30 Wheatbridge Road, Chesterfield, S40 2AB
- Referrals for the limited IV service should be sent to
  Long Eaton Health Centre, Dental Dept, Midland Street, Long Eaton, Nottinghamshire, NG10 1NY
  Please advise patients that there is a significant wait for this service.

Office Use Only

Date received at clinic: _____ Triaged by: _____ Date: _____

Ref to Lead Clinician for decision, if required. Name: _____ Date: _____

Accept: Yes/No **To be seen by:** Specialist ❑ SDO ❑ DO ❑ STR ❑ HyTh ❑ Student ❑