Kernow Clinical Commissioning Group

PAEDODONTIC REFERRAL PROFORMA (Non Orthodontics)

PATIENT DETAILS					
Referral date:			**NHS Number:**		
First name:			**Surname:**		
Address:					
Date of birth:					
Preferred contact number (mobile, home, work):			**Translator required? Y / N** **If yes, 1st language of the patient:**		
Reason why patient cannot be treated in your practice:					
Relevant Medical History			**Current medication:**		
Allergies or adverse reactions:					
Referral Criteria:	URGENT	ROUTINE	**Is the patient in pain?**	YES	NO

DENTIST'S / REFERRER'S DETAILS	
Dentist's/Referrer's Name & Address: *(please print)*	**Doctor's Name & Address:**
Dentist's/Referrer's Telephone Number: **PLEASE CHECK ALL THE ABOVE DETAILS ARE CORRECT**	
Signature (Carer/Guardian if patient is under 16 years) *(confirming the above details):*	

NHS

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Please complete the following important information for your patient:

1. Will your patient require help to communicate their dental problem? **yes / no / unsure**
2. What adjustments will be required to facilitate this patient's attendance or their ability to co-operate with oral health care?

   none / some ***(specify)*** **……**
3. Will there be a need to use sedation? **yes / no / unsure**
4. Will there be a need to use general anaesthetic? **yes / no / unsure**
5. Oral hygiene status: **good / fair / poor**
6. Are there legal and ethical barriers to providing care for your patient? **yes / no**

Reason for referral ***(please ensure detail is added in this section)***

Please circle affected teeth				
Deciduous			**Permanent**	
E D C B A	A B C D E		8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
E D C B A	A B C D E		8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Other relevant information

Please attach relevant dental radiographs for your patient *These will be returned to you*

Please send this completed proforma and radiographs to:

Kernow Health Referral Management Service
1st Floor Cudmore House, Treliske Industrial Estate, Oak Lane, Truro, TR1 3LP