NHS England

COMMUNITY/SPECIAL CARE DENTISTRY REFERRAL PROFORMA (Adults)

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 *(Circle as appropriate) I am the Patient / Carer / Parent / Other* *If other please specify* ……	

Please complete the following important information for your patient:

Ability to communicate
eg non-verbal patient or needs translation services

Ability to co-operate
Will there be a need to use sedation? yes / no / unsure

Medical Status
eg Will there be a need to make adjustments to facilitate this patient's attendance or their ability to co-operate with oral health care?

Oral risk Factors
eg smoker, diet, xerostomia, others:

Legal and Ethical barriers
Does your patient have the capacity to consent to their own dental care? yes / no

Please attach relevant up to date medical history and Dental Radiographs for your patient. If Dental Radiographs are not available please state the reason.

Reason for Referral –
provide adequate detail

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 send this completed proforma, up to date medical history and dental radiographs to;
Kernow Health Referral Management Service
1st Floor Cudmore House, Treliske Industrial Estate, Oak Lane, Truro, TR1 3LP