NHS England

COMMUNITY/SPECIAL CARE DENTISTRY REFERRAL PROFORMA (Children)

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

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):*	

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. Oral hygiene status: good / fair / poor

5. Are there legal and ethical barriers to providing care for your patient? yes / no

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