# DENTAL REFERRAL FORM Urgent Routine



**Please complete both sides and every section of this form and retain a copy for your records-**

**Incomplete referrals will be returned.**

**Attached x-rays & periodontal charts should be sealed in an envelope (marked with the patient’s name) and stapled to this form.**

**All referrals should comply with the relevant provider’s referral protocols.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **To: (please insert provider address as appropriate)** | | | | | | | **From: Practice / Clinic details (please write clearly)** | | | | | | |
| Referral & Booking Service | | | | | | | Referring Dentist……………………………………… | | | | | | |
| Leeds Dental Institute | | | | | | | Name & Address Practice/Clinic | | | | | | |
| Clarendon Way | | | | | | | ………………………………………………………………  Postcode……………………………………………………  Tel. no………………………………………………………  Fax no: ……………………………………………………..  Email: …………………………………………………….… | | | | | | |
| Leeds  LS2 9LU | | | | | | |
| **PATIENT DETAILS** | | | | | | | | | | | | | |
| Full name: | | …………………………… | | | | | Patient’s address: ………………………………………  ……………………………………………………………  ……………………………………………………………  ……………………………………………………………  Postcode……………………………………………… | | | | | | |
| Parent/guardian: | | …………………………… | | | | |
| Date of birth: | | …………………………… | | | | |
| Mobile tel. no: | | …………………………… | | | | |
| Daytime Tel umber: | | …………………………… | | | | | NHS number ……………………………………………… | | | | | | |
| **PATIENT’S MEDICAL PRACTITIONER** | | | | | | | GP practice name & address: | | | | | | |
| GP: …………………………………………………… | | | | | | | ……………………………………………………………  …………………………………………………………… | | | | | | |
| Tel. no: | …………………………………… | | | | | |
| Fax no: | …………………………………… | | | | | | Postcode: ………………………………………………. | | | | | | |
|  | | | | | | | | | | | | | |
| **Section A - Reason for referral** - please tick relevant dental speciality box(es): | | | | | | | | | | | | | |
| 🞏Dental radiography | | |  | 🞏Oral Maxillofacial Surgery | | | | |  | | 🞏Oral Medicine | |  |
| 🞏Children’s Dentistry | | |  | 🞏Orthodontics  (*specialist form to be completed and attached)* | | | | |  | | 🞏Periodontics | |  |
| 🞏Restorative Dentistry 🞏Prosthodontics 🞏Endodontics  (*Specialist form to be completed and attached*) | | | | | | | | | | | | |  |
| **ATTACHMENTS -** appropriate radiographs are essential, if not attached please state reason | | | | | | | | | | | | | |
| Radiographs attached:  Date Radiograph taken: | | | | | | 🞏 tick if yes | | Periodontal charting attached: | | | | 🞏 tick if yes | |
| **PATIENTS PAST DENTAL REFERRAL HISTORY** | | | | | | | | | | | | | | |
| Previous Dental referral | | | | | 🞏 Yes 🞏 No If yes please complete the following | | | | | | | | | |
| Date of last dental referral: | | | | | Where patient was treated : | | | | | Reason for last referral: | | | | |
| **PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** | | | | | Have you discussed the nature of the referral with the patient **Yes 🞏 No 🞏**  Have you discussed the risks associated with the referral **Yes 🞏 No 🞏**  Has the patient understood and consented to the referral **Yes 🞏 No 🞏** | | | | | | | | | |

Please complete all sections below, for those not applicable to the referral please put in **N/A**, if any sections are blank the referral will be returned delaying the patients treatment. If you do not have sufficient room please continue on a separate sheet quoting the patients name and DOB along with the relevant section letter that the additional information applies to in order to avoid any confusion.

|  |
| --- |
| **Section C:** Clinical reason for referral – provisional diagnosis/treatment – description of problem/lesion : |
| **Section D:** Patients current treatment plan in association with this referral : |
| **Section E:** Have the options of anaesthesia been discussed with the patient Yes 🞏 No 🞏  Please state agreed method  If you think a **GENERAL ANAESTHETIC** is required please state your reasons here: |
| **Section F:** Previous medical history – current medication : |
| **Section G:** Any other relevant information or attachments: |

|  |  |
| --- | --- |
| Signature of referring practitioner: | Date: |
| Print Name…………………………………………………………………………………  **Please check that all sections are complete to prevent the return of the referral.** | |

**PATIENT CHOICE**

Have you informed your patient that they may be offered a choice of provider where clinically appropriate?

**Yes 🞏 No 🞏** Please issue them with the choice leaflet