# 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.**

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| **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: …………………………………………………….… |
| LeedsLS2 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.

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| --- |
| **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 methodIf 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