General Restorative Referral Form

Leeds Dental Institute

The Leeds Teaching Hospitals NHS Trust

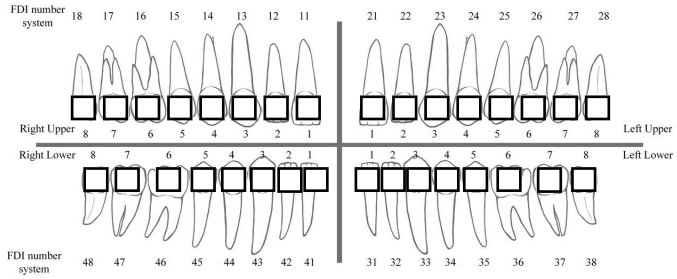
Reset Form

PRACTICE DETAILS	
Referrer Name:	Date of referral:
Practice address:	Postcode: Tel: Email:

PATIENT DETAILS		
Name:	Date of birth: (must be >16 y/o at time of referral)	Sex: Female ○ Male ○
Contact address: Postcode:	Tel (Home/work/mobile): NHS no/Hospital no:	
Medical history:		

Please state which service you would like: Diagnosis & treatment planning ☐ Treatment ☐

Charting of teeth present:



BPE score:

*ALL cases with a BPE score of 4 require a 6-point pocket chart and plaque score attached to the referral

Please indicate (for our info) **if the patient is in a high priority category below:**

- ☐ Patients who have a history of head and neck cancer
- ☐ Patients whose referral is due to dental trauma
- ☐ Patients who have developmental anomalies (eg: Hypodontia, Cleft, AI/DI)

Please tick to confirm that you have provided a periapical radiograph of diagnostic quality: ☐

The referring dental practitioner must confirm that the following requirements have all been met:

THE PATIENT

The patient must have access to regular dental care. The referring dentist must provide all monitoring and follow up treatment that is required. The referral should have occurred as a result of a full mouth examination and comprehensive oral health assessment.

Primary disease (dental caries or periodontal disease) must have been treated effectively and the oral health should be stable. Yes ☐ No ☐

The patient must have good oral hygiene levels and be motivated to receive complex dental care. Yes ☐ No ☐

The patient is able to have treatment carried out under local analgesia and they **DO NOT** require sedation or GA for dental treatment. Yes ☐ No ☐

Please provide a brief history of the problem being referred and synopsis of recent intervention. Detail on the reason why this patient requires specialist restorative advice or treatment is required. Please attach all relevant radiographs and photos to the referral – referrals WILL NOT be accepted without radiographs.

SIGNATURE:

Date Signed:

SAVING & SUBMITTING THE FORM

Please attach and email it to leedsth-tr.restorativereferral@nhs.net from an NHS.net email account. Please also include any radiographs or clinical photographs taken.

Alternatively, attach radiographs directly above and press submit button below.

Submit