**Paediatric Dentistry**

**Charles Clifford Dental Services Referral Proforma**

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| Patient name Click here to enter text.Title Click here to enter text. Female ☐ Male ☐ Date of Birth Click here to enter text.Address\_Click here to enter text.Post code Click here to enter text.Home Telephone Click here to enter text.Mobile Click here to enter text.NHS number Click here to enter text. | Referrer name Click here to enter text.**V. Code** (Dental Practices) Click here to enter text.Address Click here to enter text.Post Code \_Click here to enter text.Tel No Click here to enter text.E mail address Click here to enter text. |
| GMP Name & Address: |
| Name of Legal Guardian: |

**Date of Referral** Click here to enter a date. **Urgency of Referral Routine ☐ Urgent ☐**

(*give reason if urgent*) Click here to enter text.

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| **Is your referral for:**Advice only ☐ | Treatment ☐ |
| **CLINICAL INFORMATION:****DETAILED REASON FOR REFERRAL** Main reason for referral: Caries ☐ Trauma☐ Pathology ☐ Dental anomaly ☐ Other☐*(Please tick)*  |
| **Please state why you are referring this patient and any treatment previously provided/attempted:** |
| **PRIOR TO REFERRAL. Please note the referral will not be accepted unless prevention has been implemented and appropriate radiographs taken**  |
| 1. The following have been undertaken in accordance with DOH/BASCD tool kit prevention:
2. Toothbrushing instruction ☐ b) Diet advice ☐ c) Fluoride varnish ☐

Date of last application Click here to enter text.d) Fissure sealants ☐ 1. Relevant radiographs enclosed ☐
2. If referral is for general anesthetic (GA) I can confirm that I have discussed the risks of GA and alternatives with the legal guardian ☐
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| **MEDICAL HISTORY** |
| **CURRENT AND RECENT MEDICATION** |
| **ADDITIONAL RELEVANT INFORMATION/ENCLOSURES*****(include patient issues, social circumstances, interpreter language and special needs)*** |
| **Name of referring dentist/health profession** **Print name** Click here to enter text.**Signature of referring dentist/health professional** Click here to enter text. **Date**Click here to enter a date.**IF DETAILS ARE INCOMPLETE THIS LETTER WILL BE RETURNED – PLEASE SEE REFERRAL PROTOCOL** |