**Specialist Periodontal Services Referral**

**Charles Clifford Dental Services Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient name Click here to enter text.Title Click here to enter text. Female  Male  Date of Birth Click here to enter text.  AddressClick 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.  Email Address Click here to enter text. | |
| GP Name & Address | | | |
| Date:Click here to enter a date. | | Interpreter required  LanguageClick here to enter text. | |
| Pre-Referral Checklist (*Tick as appropriate)*  Prior to referral for periodontal treatment, where indicated, all patients should have had:  Oral health education, including the use of interproximal cleaning aids.  Subgingival professional mechanical plaque removal **with the use of local anaesthetic**  **Pre and post-operative** 6-point pocket charts, bleeding index and plaque index **with dates of examinations**  Diagnostic quality radiographs of all affected teeth **with dates of examinations**  Smoking cessation advice or referral to cessation services (if appropriate)  Treatment to stabilise any other primary disease  If any of the above has not been completed, please state why below in order for the referral to be considered: | | | |
| **Medical History**  (Including conditions, medications and allergies) | | | |
| **Details of treatment undertaken to date** | | | |
| **BPE**   |  |  |  | | --- | --- | --- | | Click here to enter text. | Click here to enter text. | Click here to enter text. | | Click here to enter text. | Click here to enter text. | Click here to enter text. | | | Where BPE code 4 please provide Pre and Post op 6-point pocket charting and radiographs of diagnostic quality of all affected teeth with dates of examinations. Prints of digital radiography must be of diagnostic quality. | |
| **Provisional Periodontal Diagnosis**  **Periodontitis:**  **Extent** (Molar-Incisor/Localised/ Generalised):  **Staging** (I-IV):  **Grading** (A-C):  **Stability** (Stable/ in Remission/ Unstable):  **If other diagnosis please complete ‘Risk Factors’ and ‘Reason for Referral’ sections.** | | **Risk Factors:**  **Smoker** (How many, and for how long?)  **Ex-Smoker** (When did the patient give up?)  **Vaper/E Cig** (Nicotine containing?)  **Diabetes** (Well controlled, or uncontrolled?)  **Family History** of Periodontal Disease | |
| **Plaque Score %** (For engaging patients this should be <20% or a reduction of >50%) |  | **Bleeding Score %** (For engaging patients this should be <30% or a reduction of >50%) |  |
| **Reason for Referral** (*Tick as appropriate)***:**  Severe periodontal disease (Stage III/IV) where primary care treatment has been unsuccessful and plaque score <20%  Rapidly progressing periodontal disease (Grade C), judged by severity of periodontal destruction relative to age or rate of periodontal breakdown in presence of plaque score <20%  Need for surgical management (e.g. mucogingival procedures for recession, open flap debridement, regenerative procedures, crown lengthening). Photographs are beneficial for such referrals.  Increased risk of periodontal disease due to a medical condition (e.g. poorly controlled diabetes, drug induced gingival overgrowth, immunosuppressive therapy, connective tissue disorders)  Risk of complications from periodontal treatment (e.g. bleeding disorders, immunocompromised)  Peri-implantitis where the implants have been placed under an NHS contract  Requirement for complex Restorative treatment planning  Specialist opinion only  Other: | | | |

**Conditions of Referral**

By making this referral, I understand that:

* I will continue to see my patient for routine and emergency dental care
* Not all patients will be accepted for treatment, and my patient may be referred back with a plan outlined
* If my patient is deemed non-engaging, they will not be taken on for treatment
* I may be asked to undertake some aspects of the treatment plan through a shared care approach
* Upon completion of treatment, the patient will be discharged back to me for ongoing supportive periodontal care
* If the referral is incomplete, it may be returned to me and delay the possible assessment of my patient

**Confirmation and Signature of Referring Practitioner:**

I confirm that I have done the following:

Explained to the patient the exact reason for the referral and the patient understands that an explanation of the problem will be given but they may not be accepted for treatment at the hospital.

I have read the CCDS Periodontal Referral Guidelines document and accept the conditions of referral.

I have included the following information:

A fully completed referral form

**Pre and post-operative** 6-point pocket charts, bleeding index and plaque index **with dates of examinations** (where appropriate) - \* please include numbered pocket charts rather than diagrammatic

Diagnostic quality radiographs of all affected teeth **with dates of examinations**

**Print Full Name:**

**Signature:**

**Date:**