**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 ☐ | |
| **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** | |