**Specialist Prosthodontic Referral**

**Charles Clifford Dental Services Referral Form**

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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.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.E mail address Click here to enter text. |
| GP Name & Address |

Date:Click here to enter a date. Interpreter required ☐

 Language Click here to enter text.

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| Relevant medical history: |

Please state which of the following categories the referral relates to:

**High priority categories**

Developmental Defects ☐

Recent Acute Trauma ☐

Head and Neck Oncology ☐

General Systemic Risk Factors (e.g. Bisphosphonates/Monoclonal antibodies ☐

**Lower priority categories (tick all that apply)**

**Please note that these groups may not be accepted for consultation**

Complete dentures ☐ Implants (placed at CCDH) ☐

Partial dentures ☐ Implants (non- CCDH) ☐

Toothwear ☐ Minor Oral Surgery ☐

Complex and non-dental patient management issues (e.g. gag reflex) ☐

Failing crown/bridgework ☐

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| **Charting of teeth present** |

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| **UR**Click here to enter text. | **UL**Click here to enter text. |
| **LR**Click here to enter text. | **LL**Click here to enter text. |

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| **Is the patient caries free?** | Yes ☐ No (include reasons) ☐ |
| Justification for patient being referred with active caries:Click here to enter text. |
| **Please state and date the most recent BPE code** |

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| --- | --- | --- |
| 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. |

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| Details of current prostheses : Click here to enter text. |
| If BPE code 3 or 4 has been identified give details of the patient’s current and active periodontal treatment/maintenance plan below: Click here to enter text. |

For accepted referrals, patients will be seen initially for diagnosis and treatment planning only. Patients accepted for treatment will primarily be those presenting in need of high complexity or high priority care. A small number of patients requiring lower complexity cases may be accepted for teaching and training purposes, where appropriate. Please indicate which level of service you would like under those circumstances:

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| --- | --- |
| Diagnosis & treatment planning only ☐ | Treatment (teaching and training case) ☐ |

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| Please provide details of the reason for referral, any recent intervention or details of treatment provided thus far, and justification for the patient to be managed in secondary care: Click here to enter text. |

Any lower complexity cases that cannot be accepted for treatment on teaching or training clinics will be returned to the referring practice with a report following diagnosis and treatment planning. Where the suggested treatment plan is felt to be outside the skillset of the referring practitioner (Performer), responsibility for arranging appropriate care rests with the Provider of the referring practice.

Please tick this box to confirm you have read and understood this statement ☐

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| **For office use only**  |
| Receipt date stampAccept ☐Reject ☐Reason for rejection: Click here to enter text. | Accepted referral allocationImplants ☐ Perio ☐Urgent ☐ Endo ☐ONC ☐ Prostho ☐ Hypo ☐ Restorative ☐ Specific clinic: Click here to enter text. |