**Specialist Endodontic 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 service you would like:** Diagnosis & treatment planning Treatment |
| 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.  | ☐ |
| The patient must have good oral hygiene levels and be motivated to receive complex dental care.  | ☐ |
| The patient should understand that if accepted for treatment, they must be available to attend the department for several long appointments (90 minutes duration) following the consultation | ☐ |
| The patient is able to have treatment carried out under local analgesia and they **DO NOT** require sedation or GA for dental treatment | ☐ |
| The patient should understand that following endodontic treatment, a definitive coronal restoration will be required and must be provided by the referring practitioner. The associated fee for this should be made clear to the patient and agreed before referral.       | ☐ |

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| **Please indicate** (for our info) **if the patient is in a high priority category below:**Patients who have received radiotherapy to the head and neck region and require endodontic treatment. ☐Patients who have endodontic problems and have received anti-resorptive drug therapy (e.g. history of IV bisphosphonates, Denosumab, long term oral bisphosphonates of more than 4 years duration) ☐Dental trauma or developmental cases requiring specialist endodontic treatment (e.g. immature/open apex, dens in dente, hypodontia, cleft patients, etc.) ☐Medically compromised patients where extractions would be contra-indicated ☐ |

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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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| **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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| **THE TOOTH**

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| **Tooth of concern: UR** Click here to enter text. **UL** Click here to enter text.  **LL**Click here to enter text. **LR** Click here to enter text. |

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| The tooth should have enough sound structure to allow application of a rubber dam clamp | **☐** |
| The tooth should have sound dentine of at least 2mm high and 1mm wide above the gingival margins to allow a ferrule for a predictable restoration | **☐** |
| The tooth should have stable periodontal health | **☐** |
| There must be clear, important (strategic) reasons to retain the tooth. For example: |
| The tooth is in the aesthetic zone and the patient would be distressed by its loss | **☐** |
| Loss of the tooth would result in functional problems, such that the patient would have fewer than 10 pairs of opposing, occluding teeth (commonly referred to as the shortened dental arch) | **☐** |
| The tooth serves as an important abutment for a fixing bridge or removable denture  | **☐** |

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| **Please tick to confirm that you have provided a periapical radiograph of diagnostic quality: ☐*** Grade 1 or 2 as per NRPB guidelines.
* Original films or a CD containing digital image files with appropriate patient demographic data and the date the image was obtained must be supplied
* Poor quality printouts of digital images are often of no diagnostic value and may be rejected
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| **Please select reason for referral** (NB The following may be considered appropriate reasons to refer, BUT only if the appropriate patient and tooth criteria described in the above are met).  |
| Root canal curvature > 45 degrees | ☐ |
| Recurved (S-shaped) root canals | ☐ |
| Canals that are NOT considered negotiable through their entire length based upon radiographic or clinical evidence (This is on the understanding that once the canals have been instrumented patients will usually be returned to you for completion of root canal treatment and final restoration) | ☐ |
| Developmental tooth anomalies (dens in dente, dens invaginatus, gemination, bifid apex, complex branching and C-shaped canals) | ☐ |
| Endodontic complications of trauma, for example open apices or root fracture etc., where the root fracture is in the middle or apical third and the tooth has good primary stability | ☐ |
| Management of teeth with pathological resorption. These must be considered to have a predictable favourable prognosis, based upon radiographic and / or clinical assessment | ☐ |
| Iatrogenic damage e.g. Perforations,(where the perforation does not result in a poor prognosis) ledges and blockages | ☐ |
| Complicated re-treatments e.g. well-fitting posts more than 8mm long, carrier-based obturations, feasible removal of fractured instruments | ☐ |
| Periradicular surgery where the existing root filling is of a good technical quality and the tooth has a good restorative prognosis | ☐ |

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| **Please provide a brief history of the problem being referred AND synopsis of recent intervention:**Click here to enter text. |

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