

Pate of Birth:   It is referral urgent?   It is this referral ur								
Date of Birth: 11/12/02	PAEDIATRIC DENTISTRY REFERRAL FORM (CHILDREN 15 YEARS OLD AND YOUNGER)							
Date of Birth: 11/12/02    Is this referral urgent?   Yes   No	Surname: Pai	First Name(s): Sanghoon		Gender:				
Date of Birth: 11/12/02   NHS Number: (It known)   Is this referral urgent?   11/12/02   Yes   Yes   No				☐ Male				
Date of Birth:  11/12/02    NHS Number:   Is this referral urgent?   Yes   Yes				1 <u> </u>				
Date of Birth:   11/12/02								
The child   Continue	Date of Birth:	NHS Number:						
Home Address:  E West st, sancity, Ce  Post Code: 982E 242  Borough: Phone: 2714-24422-52652  Mobile contact:  Phone:  BSL Interpreter Required?  Medical History (attach additional information as required)  Please record here any mobility / transport issues:  Dental History 1. Attendance: Is this child?  A regular attender Occasional, in trouble attender Never been before 3. In the last 3 years have any other children in the family had teeth out because of decay: Yes No 5. Toothbrushing and sugar in the diet: Who usually brushes the child's teeth at bedtime? The child An adult  7. Does the child usually have a sweet drink at bedtime? Yes No No S. Dietary advice to reduce free sugars in food and drinks Yes No				_				
Home Address:  E West st, sancity, Ce  Post Code: 982E 242 Phone: 2714-244422-526652 Robbile contact:  BSI. Interpreter Required?  Post Code: Borough: Phone: Which language? Spanish  Medical History (attach additional information as required)  Medical History (attach additional information as required)  List all Medication (attach additional information as required)  Please record here any mobility / transport issues:  Dental History 1. Attendance: 1. St his child?  A regular attender  Occasional, in trouble attender  Never been before 3. In the last 3 years have any other children in the family had teeth out because of decay:  Yes  No  No  S. Toothbrushing and sugar in the diet: Who usually brushes the child's teeth at bedtime? The child An adult  7. Does the child usually have a sweet drink at bedtime? Yes No  No  No  8. Dietary advice to reduce free sugars in food and drinks Yes No				l <u> </u>				
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Secure Email:	1242 59	58		
Post Code: 980e 242	-	Mobile +12 242		
Address: 008-928 Some st, somecity, BE				
Job Title:	Organisa DSD Med		Date Received (office use)	
Name of Referrer Dr Arham Akheel	2	Date of referral 22-04-21		
What has been explained to parents/guardian?  Behaviour management Local anaesthesia Inhalation sedation Intravenous sedation General anaesthesia	ָ   [	Radiographs:  Not possible Enclosed Sent digitally		
Tooth surface loss – e.g. erosion  Additional History:				
Dental Caries – Pre cooperative (under 6)  Dental caries – Over 6 years (expand under history why referral should be accepted)  Dental trauma - Primary and permanent. (expand under history)  Opinion about poor quality first permanent molars. No RCT.	Dental Anom tooth structu shape, size, for Periodontal ( Soft Tissue Comucoceles/ L	surgical management e.g. unerupted teeth/ broken down teeth  (gum) problems  Conditions –  Surgical management e.g. unerupted teeth/ broken down teeth  Complex medical problems – expand below		
How does the above patient meet	the Paediatri	ic Dentistry Refe	rral criteria?	
☐ Temporary fillings☐ No treatment attempted	<u> </u>	<ul><li>Any other treat</li><li>Unable to treat</li></ul>		
Fissure sealants applied to permanent molars		Behaviour management		
Fluoride varnish applied		Failed attempt at local anaesthesia		

THIS REFERRAL <u>WILL NOT</u> BE ACCEPTED WITHOUT COMPLETION OF ALL SECTIONS. ON COMPLETION PLEASE SEND THE REFERRAL FORM TO RELEVANT CDS PROVIDER



## **REFERRAL / TRIAGE OUTCOME**

## (For completion by CDS provider)

Date Referral Received:	1	1		
Date of Referral Triage:	1	/		
Triage undertaken by:	Name		Job Title	
OUTCOME OF REFERRAL				
ACCEPTED				
Suggested Provider:				
Level I (Training and Education)				
Level II (CDS)				
Level III (Acute Care)				
DECLINED				
Reasons				
Insufficient Information with regards to:			☐ Patient details	
			Reasons for the referral	
2. Radiographs			Absent when stated enclosed / electronically transmitted	
3. Inappropriate level of patient complexity to specific unit			☐ No evidence that complexity of referral is appropriate to a Level II service	
			No evidence that complexity of referral is appropriate to a Level III service (try a Level II service)	

Please send this form back to <a href="mailto:BROMH.dentalreferrals@nhs.net">BROMH.dentalreferrals@nhs.net</a>