NHS England

PAEDIATRIC DENTISTRY REFERRAL FORM (CHILDREN 15 YEARS OLD AND YOUNGER)

Surname:	**First Name(s): Sanghoon Pai**	**Gender:** ☐ Male ☐ Female ☐ Prefer not to say
Date of Birth: **11/12/2147**	**NHS Number: 21512784834848944949** (If known)	Is this referral urgent? ☐ Yes ☐ No

Home Address: E West st, ijlmnk city, Cv **Post Code: 2749724** **Borough:** **Phone: 218408-2049820480-24214** **Mobile contact:**	**PREFERRED INFORMATION** **GP Name :** **GP Address:** **Post Code:** **Borough:** **Phone:**
BSL Interpreter Required? ☐ Yes ☐ No	**Which language?**
Medical History (attach additional information as required) **Please record here any mobility / transport issues:**	**List all Medication** (attach additional information as required)

Dental History

1. Attendance:
Is this child?
☐ A regular attender
☐ Occasional, in trouble attender
☐ Never been before

2. Dental pain and antibiotics:
Over the last week, has the child had toothache?
☐ Yes
☐ No

3. In the last 3 years have any other children in the family had teeth out because of decay:
☐ Yes
☐ No

4. Over the last 3 months, has the child had antibiotics for tooth problems?
☐ Yes
☐ No

5. Toothbrushing and sugar in the diet:
Who usually brushes the child's teeth at bedtime?
☐ The child
☐ An adult

6. Preventive advice that has been given, prior to referral:
Toothbrushing at bedtime and one other time with fluoride toothpaste with at least 1,000 ppm Fluoride
☐ Yes
☐ No

7. Does the child usually have a sweet drink at bedtime?
☐ Yes
☐ No

8. Dietary advice to reduce free sugars in food and drinks
☐ Yes
☐ No

Dental treatment provided, tick ALL relevant boxes:

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- ❑ Fluoride varnish applied
- ❑ Fissure sealants applied to permanent molars
- ❑ Temporary fillings
- ❑ No treatment attempted
- ❑ Failed attempt at local anaesthesia
- ❑ Behaviour management
- ❑ Any other treatment?
- ❑ Unable to treat (specify reason)

How does the above patient meet the Paediatric Dentistry Referral criteria?

- ❑ Dental Caries – Pre co-operative (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.
- ❑ Tooth surface loss – e.g. erosion
- ❑ Dental Anomalies – altered tooth structure, number, shape, size, form
- ❑ Periodontal (gum) problems
- ❑ Soft Tissue Conditions – mucoceles/ ulcers
- ❑ Disorders of tooth eruption and loss
- ❑ Surgical management e.g. unerupted teeth/ broken down teeth
- ❑ Complex medical problems – expand below
- ❑ Complex behavioural problems unsuitable for General Practice
- ❑ Children in the care of social services e.g. Looked after children

Additional History:

What has been explained to parents/guardian?

- ❑ Behaviour management
- ❑ Local anaesthesia
- ❑ Inhalation sedation
- ❑ Intravenous sedation
- ❑ General anaesthesia

Radiographs:

- ❑ Not possible
- ❑ Enclosed
- ❑ Sent digitally

Name of Referrer
Someone who shouldn't refer me

Date of referral
22-04-21

Job Title:
Dr ducktor

Organisation:

Date Received (office use)

Address:
98124098 Being tired to create random address anymore, BE

Phone / Mobile 21424)
2948924 - 29489248

Post Code: 92849812904e 5895

Secure Email:

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

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REFERRAL / TRIAGE OUTCOME

(For completion by CDS provider)

Date Referral Received:	/ /	
Date of Referral Triage:	/ /	
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	
1. 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 BROMH.dentalreferrals@nhs.net