TRIAGING ADMIN CODE (COMPLETED ON RECEIPT):

NHS England

SPECIAL CARE DENTISTRY REFERRAL FORM (16 YEARS OLD AND ABOVE)

Surname: Sur	First Name(s): name	Gender: ❑ Male ❑ Female	❑ Prefer not to say
Date of Birth: 24/2/2525	NHS Number:	Is this referral urgent? ❑ Yes	❑ No

Home Address: Somewhere over the rainbow Post Code: Borough: Phone: Mobile contact:	GP Name: GP Address: Post Code: Borough: Phone:
Interpreter Required? ❑ Yes – what language?	❑ No
Medical History (attach additional information as required)	**List all medication** (attach additional information as required)
How does the above patient meet the Special Care Dentistry Referral criteria? ❑ Learning disabilities (mod/severe) ❑ Physical disabilities (mod/severe) ❑ Severe anxiety/phobia ❑ Mental health problems (severe) ❑ Complex medical conditions ❑ Domiciliary care required ❑ Bariatric (severely overweight) ❑ Homeless people, substance misuse **Radiographs:** ❑ Not possible ❑ Enclosed ❑ Sent digitally	**What dental treatment and prevention strategies have already been provided?** **What dental treatment is required?** **What treatment modality is required?** ❑ Behavioural management ❑ Local anaesthesia ❑ Inhalational sedation ❑ Intravenous sedation ❑ General anaesthesia
Please record here any mobility / transport issues and relevant social history:	

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BRITISH DENTAL ASSOSCIATION CASE MIX TOOL

Guidance on commissioning for Special Care Dentistry recommends that commissioners appraise themselves of the complex needs of patients this service. It can also assist in ensuring that the patient is seen by the most appropriate service.

This validated Case Mix Tool is designed to measure patient complexity using six identifiable criteria applied to a weighted scoring system. Please assign a score for each criteria and add these together to give a total banded score:

CASE MIX COMPLEXITY*	Please tick the most appropriate score for each domain:		
Communication	No issues	0	
	Mild restriction	2	
	Moderate restriction	4	
	Severe restriction	8	
Cooperation	Full cooperation	0	
	Some difficulty	3	
	Considerable difficulty	6	
	Serious difficulty	12	
Medical status	No impact on care	0	
	Some impact	2	
	Moderate impact	6	
	Severe impact	12	
Oral risk factors	Minimal risk	0	
	Moderate risk	3	
	Severe risk	6	
	Extreme risk	12	
Access to care	Unrestricted	0	
	Moderately restricted	2	
	Severely restricted	4	
	Extremely restricted	8	
Legal and ethical barriers	None	0	
	Some	2	
	Mod	4	
	Multi-professional consultation	8	

TOTAL BANDED SCORE (ADD SCORES ASSIGNED AS ABOVE)	

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Name of Referrer:		**Date of referral:**
Job Title:	**Organisation**	**Date received (office use):**
Address: **Post code:** **Phone/Mobile:** **Secure email:**		
Details of the NHS Special Care Dental Service where this referral is to be sent:		
❑ **I confirm that I have informed the patient / parent / carer that this form will be sent for triaging and may be forwarded to other appropriate NHS dental care providers.**		
Signature:		

NHS Fees are charged for all dental treatment carried out by the Community Dental Services.
If the Patient intends to claim FREE or REDUCED cost Dental Care please indicate exemption criteria and advise the patient to bring proof to appointment. (Please note treatment may be deferred until evidence is provided)

- ❑ Under 18 or 18 and in full time education.
- ❑ Pregnant or had a baby in the last 12 months.
- ❑ In possession of an HC2 NHS Certificate.
- ❑ An NHS tax credit exemption certificate.
- ❑ Pension Credit Guarantee Credit.
- ❑ Income Support.
- ❑ Income based Job Seekers Allowance.
- ❑ Income-related Employment & Support Allowance
- ❑ HC3 certificate that limits the amount paid.
- ❑ Universal Credit

The following on their own DO NOT entitle the patient to help with health costs:

- Incapacity Benefit
- Disability Living Allowance
- Pension Savings Credit
- Contribution Based Job Seekers Allowance
- NHS Prescription Charge Exemption
- Medical Exemption Certificate

NHS Treatment band	❑ **1** ❑ **2** ❑ **3**
Patient charge	**£**
Paid by patient	**£**

ON COMPLETION OF TREATMENT PLEASE DISCHARGE THE PATIENT TO:

- ❑ General Dental Practitioner
- ❑ Community Dental Service

THIS REFERRAL WILL NOT BE ACCEPTED WITHOUT COMPLETION OF ALL SECTIONS

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REFERRAL / TRIAGE OUTCOME

(this will be modified once preferred providers are identified)

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)	