Berkshire Healthcare
NHS Foundation Trust

Berkshire Community Dental Service
Referral Form

**This form is for Health and Social Care professionals,
family wishing to refer a patient/client or for people wishing to self-refer.**

PATIENT DETAILS			
Name:	Date of Birth:	Male/Female:	NHS number *(If known)*
Address *(including postcode)*			Ethnicity:
Telephone numbers			
Home:	Work:	Mobile:	
Email:			
Details of next of kin/responsible person:			
Patient Mobility Status: [ ] Housebound [ ] Wheelchair user [ ] Needs hoist or assistance to transfer to chair			
Additional Information - communication/language difficulties, visual or hearing impairment, challenging behaviour:			
Patient Exemption Status: [ ] Exempt [ ] Not exempt ***Evidence of exemption must be provided at the first appointment*** If exempt, please indicate reason: [ ] Under 18 years [ ] 18 years and in full time education [ ] Pregnant [ ] Had a baby in last 12 months [ ] Income support [ ] Income based jobseeker's allowance [ ] Income related employment & support allowance [ ] Pension credit guarantee credit			
Disabilities (please tick all that apply): [ ] Learning disability [ ] Physical disability [ ] Mental Health problem [ ] Dementia [ ] Complex Medical problem [ ] Hearing impairment [ ] Visual impairment [ ] Language			
Preferred method of communication: [ ] Letter [ ] Large Print Letter [ ] Telephone [ ] Email [ ] Text			

GP DETAILS	
Name:	Telephone number:
Address *(including postcode)*	
Details of Consultant *(if required) n/a*	
Please attach a recent medical history form signed by the patient or complete the medical history form on Page 3.	

REFERRER'S DETAILS		
Name of Referrer:	Signature:	Date:
Relationship to Patient &/or Job Title:		
Address *(including postcode)*		
E-mail Address:		Telephone Number:
I have provided the patient with a copy of the referral form: ☐ Yes ☐ No		
Patient /Next of Kin Signature:		Date:

DETAILS OF REFERRAL

Reason for Referral – *see p4 for guidance on criteria:*

- ☐ Child with additional needs such as learning, physical or severe medical disability
- ☐ Person with learning, physical or severe medical disability impacting on dental treatment
- ☐ Person with severe mental health problem or dementia impacting on dental treatment
- ☐ Person with severe dental phobia whose needs can't be met in NHS sedation services
- ☐ Person unable to leave home and may require domiciliary treatment - *assessed on an individual basis*

Please give a description of the dental problem? ***e.g. pain/loose tooth/broken filling***

Please return the completed forms via post to:
Referrals, CDS HQ, Skimped Hill Health Centre, Skimped Hill Lane, Bracknell, RG12 1LH

For any queries regarding the status of your referral, please ring our referral hub

Call 0118 904 1525

Alternatively, this form can be emailed direct to cds.hq@berkshire.nhs.uk from a secure email address.

Please note that this referral form will be returned to you if it is not fully completed

Confidential Medical History Questionnaire

This medical history form must be completed.

If you answer yes to any questions, please give as much detail as possible in the box provided.

Name:	**Date of Birth:**
Mobile Phone ***(for text reminders)***	**Home Phone Number:**
NHS Number:	**Doctor's Name and Surgery Address:**
Do you have a social or support worker? If yes, please give name and contact details:	
1. Have you ever had and heart disease/murmur or angina?	
Yes	No
2. Have you ever had heart surgery?	
Yes	No
3. Do you suffer from hypertension (High blood pressure)?	
Yes	No
4. Have you ever suffered from epilepsy/convulsions/fits/faints/blackouts?	
Yes	No
5. Have you ever suffered from any chest problems/ (Asthma/Bronchitis/TB)	
Yes	No
5. Do you or any close family members have diabetes?	
Yes	No
6. Do you suffer from any bleeding disorders or bruise easily?	
Yes	No
7. Have you ever suffered from any infectious diseases (including HIV/Hepatitis/Jaundice)?	
Yes	No
8. Do you have any renal (kidney) disease?	
Yes	No
9. Have you ever been on Bisphosphonate medication (either oral or intra venous)?	
Yes	No
10. Do you have any allergies to medicines (e.g. penicillins), substances (e.g. latex/rubber) or foods?	
Yes	No

11. Have you ever had any other serious illnesses?	
Yes	No
12. Have you ever had treatment that required you to be in hospital?	
Yes	No
13. Have you had a General Anaesthetic?	
Yes	No
14. Have you or anyone in the family ever had a bad reaction to General Anaesthetic or Local Anaesthetic?	
Yes	No
15. Do you carry a medical warning card?	
Yes	No
16. Do you regularly drink more than 14 units of alcohol a week?	
Yes	No
17. Do you smoke or chew (e.g. pan, gutkha or supari) any tobacco products (or did you in the past)?	
Yes	No
18. Do you use any recreational drugs either now or in the past?	
Yes	No
19. Please give your approximate height and weight	
Height	Weight
20. Do you have a physical disability, hearing or visual impairment?	
Yes	No
21. Do you have a learning difficulty/mental health problem or other special needs?	
Yes	No

22. Are you currently taking any prescribed medication (tablets, medicines, ointments/inhalers/contraceptives/HRT)?			
Yes		No	
If Yes, please list in the box below.			
Signed		**Date**	

Berkshire Community Dental Service
Referral Criteria Nov 2022

CRITERIA FOR REFERRAL	REASONS FOR REFERRALS TO BE RETURNED
1. Children who have had an episode of pain and/or infection from a baby tooth/teeth and are uncooperative and unable to accept with their dentist unless the child fulfils criteria 3. *Patients with asymptomatic decay in baby teeth will be rejected.* 2. Children with caries in permanent teeth who are uncooperative and unable to accept treatment. 3. Patients with a learning, physical or severe medical disability which impacts on their dental treatment. 4. Patients with severe mental health problems or dementia which impacts on their dental treatment. 5. Patients with a severe dental phobia whose needs cannot be met by NHS sedation services. *Only those who have been refused by the NHS clinics providing IV sedation or have a learning disability will be considered.* 6. Patients who are unable to leave their home and may require domiciliary treatment.	a) Does not fulfil criteria b) Referral form incomplete **EXCLUSIONS** a) Children with asymptomatic decay in baby teeth. b) Patients referred for IV sedation who do not have a learning disability or have not previously been referred to an NHS IV clinic. c) Orthodontic Extractions.

Please Note:

- All patients will be assessed against these criteria both on referral and at the consultation appointment and those referrals deemed inappropriate will be discharged.
- Children who fulfil criteria 1 or 2 and do not have a disability will normally be referred to their dentist on completion of the course of treatment.

  Patients with disabilities or requiring domiciliary care may be accepted for continuing care on an individual basis.