Berkshire Healthcare
NHS Foundation Trust

Community Dental Service

Referral form

This form is for health and social care professionals and/or family wishing to self-refer a patient into the service.

This referral form is **not** intended to be used for accessing emergency dental care. For emergency dental care, please contact NHS 111, or your general dentist, if you have one.

Patient details

Name:	
Date of birth *(DD/MM/YYYY)*:	NHS number *(if known)*:
Sex: ◯ Male ◯ Female	Ethnicity:
Address *(including postcode)*:	
Email address:	
Phone number(s): Mobile: Home: Work:	
Details of next of kin/responsible person: *A relative or carer with knowledge of the patient's medical and dental problems should accompany any patient with communication or mobility problems.*	
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, etc.):	

Patient exemption status: ◯ Exempt ◯ Not exempt

If exempt, please indicate reason:

☐ Under 18 years old

☐ 18 years old and in full-time education

☐ Pregnant

☐ Had a baby in the last 12 months

☐ Pension Credit Guarantee Credit

☐ Universal Credit

☐ Income support

☐ Income-based jobseeker's allowance

☐ Income-related employment and support allowance

Disabilities (please tick all that apply):

☐ Learning disability

☐ Physical disability

☐ Severe mental health problem

☐ Autism

☐ Dementia

☐ Complex medical problem

☐ Hearing impairment

☐ Visual impairment

☐ Language

☐ Behavioural problems

☐ Bleeding disorder

☐ Life-limiting medical condition

Preferred method of communication:

☐ Letter ☐ Large print letter ☐ Telephone ☐ Email ☐ Text

Referrer's details

Name of referrer:	
Signature:	Date *(DD/MM/YYYY)*:
Relationship to patient/ job title:	
Address *(including postcode)*:	
Phone number(s): Mobile: Home: Work:	
Email address:	
I have provided the patient with a copy of the referral form: ☐ Yes ☐ No	
Patient/ Next of Kin signature:	
Date *(DD/MM/YYYY)*:	

GP details

Name of GP:
Address *(including postcode)*:
Phone number:
Details of consultant (if required):

Details of referral

Reason for referral: *(see criteria for guidance)*

☐ 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

☐ Autism ☐ ADHD

☐ ADD ☐ Dyslexia

☐ Dyscalculia ☐ Dyspraxia

☐ Acquired brain injury

Has the patient been officially diagnosed with their condition? ☐ Yes ☐ No

Please provide more details of the reason *(this form will be rejected if no details are provided)*:

Description of the dental problem *(e.g., pain/ loose tooth/ broken filling)*

When did the patient last see a dentist?

Was this private or NHS? ◯ Private ◯ NHS

Why is patient not going to their dentist or a local dentist for this problem?
How does the patient go to see the GP?
How does the patient attend hospital appointments?
Does the patient have any access requirements you would like us to be aware of?
Is the patient able to attend the surgery? ☐ Yes ☐ No If 'No', please state a reason:
Does the patient have carers attending their home to help? ☐ Yes ☐ No If 'Yes', how many times a day do they attend?

Please return the completed forms via post to:

Referrals
Community Dental Service
Skimped Hill Health Centre
Skimped Hill Lane
Bracknell
RG12 1LH

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

For any queries regarding the status of your referral, please call our referral hub: **0118 904 1525**.

Please note: 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 *(DD/MM/YYYY)*:	NHS number *(if known)*:	
Sex *(assigned at birth)*: ◯ Male ◯ Female	Home phone number:	
Mobile phone number *(for text reminders)*:		
Doctor's name and surgery address *(including postcode)*:		
Please give your approximate height and weight: Height: Weight:		
Do you have a social or support worker? If 'Yes', please give name and contact details:		◯ Yes ◯ No
1. Have you ever had any heart disease/murmur or angina? If 'Yes', please provide detail:		◯ Yes ◯ No
2. Have you ever had heart surgery? If 'Yes', please provide detail:		◯ Yes ◯ No
3. Do you suffer from hypertension (high blood pressure)? If 'Yes', please provide detail:		◯ Yes ◯ No
4. Have you ever suffered from epilepsy/ convulsions/ fits/ faints/ blackouts? If 'Yes', please provide detail:		◯ Yes ◯ No
5. Have you ever suffered from any chest problems (asthma/ bronchitis/ TB)? If 'Yes', please provide detail:		◯ Yes ◯ No

6. Do you or any close family members have diabetes? If 'Yes', please provide detail:	◯ Yes ◯ No
7. Have you ever suffered from any infectious diseases (e.g. HIV/ hepatitis)? If 'Yes', please provide detail:	◯ Yes ◯ No
8. Do you/ any close family suffer from a bleeding disorder/bruise easily? If 'Yes', please provide detail:	◯ Yes ◯ No
9. Do you have any renal (kidney) or liver disease (e.g. hepatitis/ jaundice)? If 'Yes', please provide detail:	◯ Yes ◯ No
10. Have you ever been on Bisphosphonate medication (oral or intravenous)? If 'Yes', please provide detail:	◯ Yes ◯ No
11. Do you have any allergies to medicines, substances, or foods? If 'Yes', please provide detail (examples include penicillin, latex, or rubber):	◯ Yes ◯ No
12. Have you ever had any serious illnesses? If 'Yes', please provide detail:	◯ Yes ◯ No
13. Have you ever had treatment that required you to be in hospital? If 'Yes', please provide detail:	◯ Yes ◯ No
14. Have you ever had a general anaesthetic? If 'Yes', please provide detail:	◯ Yes ◯ No
15. Have you or any close family members ever had a bad reaction to general anaesthetic or local anaesthetic? If 'Yes', please provide detail:	◯ Yes ◯ No
16. Do you carry a medical warning card? If 'Yes', please provide detail:	◯ Yes ◯ No

17. Do you regularly drink more than 14 units of alcohol a week? If 'Yes', please provide detail:	◯ Yes ◯ No
18. Do you smoke or chew any tobacco products, including paan, gutkha, or supari, or did you in the past? If 'Yes', please provide detail:	◯ Yes ◯ No
19. Do you use any recreational drugs, or did you in the past? If 'Yes', please provide detail:	◯ Yes ◯ No
20. Could you be pregnant? If 'Yes', please provide detail:	◯ Yes ◯ No
21. Are you taking any form of contraception? If 'Yes', please provide detail:	◯ Yes ◯ No
22. Do you have a physical disability or hearing or visual impairment? If 'Yes', please provide detail:	◯ Yes ◯ No
23. Do you have a learning difficulty, mental health problem, or other special needs? If 'Yes', please provide detail:	◯ Yes ◯ No
24. Are you currently taking any prescribed medication? If 'Yes', please list below or photocopy list and attach.	◯ Yes ◯ No

Signed:	**Date:**

Community Dental Service

Criteria (updated November 2024)

Criteria for referral:

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.

Reasons for referrals to be returned:

A. Does not fulfil criteria.

B. Referral form incomplete.

Reasons for referrals to be returned:

i. Children with asymptomatic decay in baby teeth.

ii. Patients referred for IV sedation who do not have a learning disability or have not previously been referred to an NHS IV clinic.

iii. 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.