Bradford District Care NHS
NHS Foundation Trust

# Community Dental Service
# Referral Form

## Patient Details

| Title: Mr / Mrs / Miss / Other | Surname: | Other Names: | Date of Birth: |
|---|---|---|---|
| Address: ..... ..... Postcode: ..... | | | Weight: ..... Kg |
| Telephone Numbers: Home: | | Work: | Mobile: |
| NHS Number: | Name of parent / carer / support worker (if applicable): Telephone Number: | | |

## Communication requirements

**Does the patient, patient carer require an interpreter / sign language practitioner ?**

**If so, which language:** **Dialect**

**Any sensory impairment?**

## Access requirements

Is the patient in a wheelchair Yes ☐ No ☐

Do they require transport because of access issues? Yes ☐ No ☐

Any other access mobility issues:

## Which service are you referring to:

| Paediatric Special Needs: ☐ | Adult Special Needs: ☐ | Vulnerable groups: ☐ |
|---|---|---|
| ☐ Medically compromised | ☐ Medically compromised | ☐ Homeless |
| ☐ Physical disability | ☐ Physical disability | ☐ Substance misuse |
| ☐ Learning disabilities | ☐ Learning disabilities | ☐ Asylum seeker |
| ☐ Behaviour management | ☐ Mental health difficulties | ☐ Looked after child |
| | | ☐ Dementia/Cognitive impairement |

**Please give reason for referral:**

.....

.....

.....

Has this patient been referred to the service before? YES / NO

**PLEASE ENCLOSE RELEVANT RADIOGRAPHS**

**Please complete both sides of the form**

**Treatment required and degree of pain / urgency**

.....

.....

.....

**What treatment have you provided or attempted to provide (if applicable):**

.....

.....

.....

**Radiographs enclosed Yes / No**

## Medical History

**Please record any conditions, diseases, operations which are relevant:**

.....

.....

**Medication taken:**

.....

.....

**Has the patient agreed to this referral Yes / No**

**Has the patient agreed to their appointment information being shared with support workers / carers**

**Yes / No**

**Name of any Consultant involved in patients care:** _____

**Area of Speciality:** _____ **Base: AGH / BRI / St Lukes / LGI**

## Referrers details

**Name:** .....

**Position:** .....

**Address:** .....

.....

**Postcode:** .....

**Telephone No:** .....

## GMP details

**Name:** .....

**Address:** .....

.....

**Postcode:** .....

**Telephone No:** .....

**Please return completed forms to:**

**Community Dental Service**
**Referral Administrator**
**Horton Park Centre**
**99 Horton Park Avenue**
**Bradford BD7 3EG**

**Tel: 01274 251838**
**Fax: 01274 215695**
**e-mail:** salaried.dentalservice@nhs.net