Guidelines for referral to
The Solent NHS Trust
Special Care Dental Service

If you would like to refer to the following clinics:

Bitterne Health Centre
Hythe Medical Centre
Pickles Coppice Children’s Centre, Millbrook
New Milton Health Centre
Romsey Hospital
Royal South Hants Hospital
Bramblys Grange, Basingstoke
Andover Health Centre
Aldershot Centre for Health
Eastleigh Health Centre
Petersfield Hospital
Havant Health Centre
Poswillo Dental Centre, QA
Eastney Health Centre
Gosport War Memorial Hospital

Please send referral to:

Solent NHS Trust Dental Single Point of Access, Level A, Royal South Hants Hospital, Brintons Terrace, SOUTHAMPTON SO14 0YG

Tel: 023 8069 8677 Fax: 023 8071 3279

E-mail: SNHS.CentralPointofReferral@nhs.net
Referring a patient to Solent NHS Trust Special Care Dental Service

This guide is intended to assist with the appropriate referral of patients with special needs or those requiring specialist, occasional care to Solent NHS Trust Special Care Dental Service. Patients referred to this service must be registered with a GP in the Hampshire area (Southampton, Portsmouth and the rest of Hampshire).

Solent NHS Trust Special Care Dental Service provides dental care for children and adults who have a special need including those with a physical, sensory, intellectual mental, medical, emotional or social impairment or disability or a combination of these that prevent them from accessing care through the General Dental Services.

It also provides specialist occasional care, supporting care in general dental practice by providing a single or staged course of treatment as part of a joint treatment plan with the referring dentist for patients who are unable to receive care in general dental practice due to medical, physical or behavioural difficulties. Patients will usually be seen for a course of treatment then will be discharged back to the General Dental Services unless it is necessary for continuing care to be provided in this service because of the patient’s special need or disability.

Treatment may be provided under local anaesthesia, inhalation sedation, intravenous sedation for adults, or general anaesthesia for children and adults with special needs. Please note general anaesthesia is not provided for routine dental care for adults without a special need.

For those who are housebound or frail elderly people a domiciliary service can be provided.

Service Locations
Services are provided at the following dental clinic locations:-
Southampton
Bitterne, Pickles Coppice Millbrook, Royal South Hants Hospital
Portsmouth
Eastney, Gosport, Somerstown, Poswillo QA Hospital
Hampshire
Patients requiring a general anaesthetic following assessment will be treated at hospital locations including: - Southampton General Hospital, Portsmouth Hospital (Poswillo Unit), Royal Hampshire County Hospital Winchester and North Hampshire Hospital Basingstoke.

Referrals are accepted from
Dental Practitioners
General Medical Practitioners
Any other Health or Social Care Professional
Voluntary organisations and community groups
Education/special schools
Families, carers, self referral where appropriate
Referral forms

When making a referral, please use the referral forms in this document. These can be copied as required or you can use an electronic version. If you require an electronic version, please telephone us on 023 8069 8677 or e-mail SNHS.CentralPointofReferral@nhs.net

Using these forms ensures that we have all the relevant information that we require to process your referral in a timely manner. If any part of the form is incomplete the referral will be returned for completion and this could result in a delay in your patient being seen.

For all referrals please complete section A.
For referrals requiring a general anaesthetic please complete both sections A and B.

General information
Please inform the patient:-
- The reason why you are making the referral
- That their initial appointment will usually be for an assessment only
- NHS dental charges apply (unless patient is exempt)

For dentists
Routine treatment referrals
Wherever possible, please enclose recent radiographs (these will be returned at end of treatment) and any other information that will help with patient care.
Until the first appointment with the service, the referring dentist remains responsible for the provision of emergency care for the patient.

Referrals for treatment under general anaesthesia
Treatment under general anaesthesia for children and adults with special needs will only be considered as a last resort when treatment under local anaesthesia or conscious sedation is not feasible or appropriate.
Where possible all planned restorative care should be completed by the referring dentist before referring for an assessment for treatment under general anaesthesia. Please ensure both Section A and Section B forms are completed and wherever possible, please enclose recent radiographs (these will be returned at end of treatment) and any other information that will help with patient care.

Please note
- Good quality radiographs are generally required showing in full the teeth to be removed and their surroundings. Bitewing radiographs are NOT appropriate.
- If the extractions are for orthodontic reasons an orthodontic management plan must also be attached. It is generally expected that extractions for orthodontic reasons will be carried out under local anaesthetic in general practice and only referred for general anaesthetic in exceptional circumstances.
If the referral is for one or more extractions of the first permanent molars, consider the prognosis of the other first permanent molars and pursue an orthodontic opinion prior to referral if a malocclusion exists already.

Until the first appointment with the service, the referring dentist remains responsible for the provision of emergency care for the patient. On completion of treatment the patient will usually be returned to the care of the referring practitioner unless it is necessary for continuing care to be provided in the service because of their special need or disability.

**Referral criteria**

Referrals are accepted for children and adults with special care needs or those requiring specialist occasional care who cannot be managed by a General Dental Practitioner.

This includes **children** with:

- Learning disabilities
- Behavioural / management problems
- Severe physical disabilities
- Autistic spectrum disorders
- Treatment required as a result of serious dental trauma if not manageable in general practice

and **adults** with:

- Learning disabilities / challenging behaviour
- Autistic spectrum disorders
- Severe mental health problems
- Severe physical problems and those who are frail/elderly or housebound and require domiciliary care

**Referrals are not accepted for:-**

- Nervous or apprehensive adults without a special need
- Children requiring extractions for orthodontic purposes (except in exceptional circumstances)
- Adults requesting a general anaesthetic who do not meet the criteria for special needs
- On the grounds of financial hardship
# Section A

## Referral to the Special Care Dental Service

Please complete all sections

### Patient's details

<table>
<thead>
<tr>
<th>First name</th>
<th>Surname</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Title</th>
<th>Male / Female</th>
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<tr>
<th>NHS No</th>
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<table>
<thead>
<tr>
<th>Address</th>
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<table>
<thead>
<tr>
<th>Post Code</th>
<th>Telephone number:</th>
<th>Home</th>
<th>Mobile</th>
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</tbody>
</table>

Requires language translation services  Yes [ ]  No [ ]  State Language

### Doctors name and address: This section must be completed

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<thead>
<tr>
<th>Name</th>
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<table>
<thead>
<tr>
<th>Address</th>
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<table>
<thead>
<tr>
<th>Post Code</th>
<th>Telephone Number</th>
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### Referred by: details or stamp

<table>
<thead>
<tr>
<th>Name</th>
<th>Profession</th>
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<table>
<thead>
<tr>
<th>Date of referral</th>
<th>Signature</th>
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</table>

### Reason for referral

Please include details of patient's special need, reason why the patient is unsuitable for treatment in general dental practice and any attempted treatment. Please indicate clinic preference.

### Enclosures

(e.g. radiographs)
**Section A**
**Referral to the Special Care Dental Service**

**Medical history:** Please provide full details of medical history

<table>
<thead>
<tr>
<th>Physical Disability</th>
<th>Learning disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural Issues</td>
<td>Mental Health Issues</td>
</tr>
<tr>
<td>Social Issues</td>
<td>Medically Compromised</td>
</tr>
<tr>
<td>Other (please give details)</td>
<td></td>
</tr>
</tbody>
</table>

**Current medication**

**Does the patient suffer from any of the following:** please specify

<table>
<thead>
<tr>
<th>Walks unaided?</th>
<th>Wheelchair access required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires assistance of helper or carer?</td>
<td>Can transfer to dental chair without help?</td>
</tr>
<tr>
<td>Requires hoist?</td>
<td>Requires wheelchair recliner?</td>
</tr>
</tbody>
</table>

**MOBILITY:** please specify

**DOMICILIARY REQUESTS** If a domiciliary visit is required please complete this section

<table>
<thead>
<tr>
<th>Is the patient housebound?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient attend his/her doctor?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If the patient has a hospital appointment how do they get there?

<table>
<thead>
<tr>
<th>Ambulance</th>
<th>Car</th>
<th>Taxi</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient use a taxi for other activities?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

Does the patient attend appointments outside their home? e.g. hairdressers

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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</table>

Does he/she live in residential care?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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Other requirements (e.g visual or hearing impaired)
Form B

If referring specifically for treatment under a general anaesthetic please complete Section A and the following:

- I confirm that all options for treatment have been discussed with the patient / parent / carer
  
  YES □  NO □

- If the referral is for one or more extractions of the first permanent molars, have you considered the prognosis of the other sixes and if so has an orthodontic assessment been discussed.
  
  YES □  NO □

- I confirm that the risks of General Anaesthesia have been discussed with the patient / parent / carer
  
  YES □  NO □

- I confirm that the patient/parent/carer agrees to referral for possible treatment under General Anaesthesia
  
  YES…□  NO…□

PATIENT HEIGHT……………………….. PATIENT WEIGHT……………………….KG/LBS

The teeth I would like to be considered for extraction and / or conservation (tooth or teeth for priority extraction, circled) are:

________________________________________________________________________

________________________________________________________________________

I have attached radiographs (essential when permanent teeth are to be extracted)  YES…□  NO…□

I have attached the orthodontic treatment plan where appropriate  YES…□  NO…□

I agree to the referral to the Special Care Dental Service as explained to me by the referring GDP

Signed…………………………..Parent / Carer  Print Name ………………………….. Date …………

Signed ………………………………..Referring Dentist …………………………. Date …………

For office use only

Date received…………………………………………………

Referred to:……………………………………………..Date paperwork scanned……………………………

Date of appointment………………………………………… At………………………………………………

18 week clock started  YES…□  NO…□  Dealt with

SEND COMPLETED FORMS TO:  Please refer to cover page of criteria