**Solent Special Care Dental Service Referral Form for ADULTS**

**For referral by Self, Family, Carers and Non-Dental Health and Social Care Professionals**

Solent NHS Trust Special Care Dental Service provide specialised dental care for those who are unable to access dental care in the General Dental Service because of their additional needs.

Patients must be registered with a General Medical Practitioner in Hampshire, Portsmouth, Southampton or the Isle of Wight.

The referral will be considered, and we will contact you to discuss the next steps. We will then decide if a clinic or home visit is appropriate.

If we are not the right service to provide the care, we will sign post you to a more appropriate service.

# Part A About the Person

## A.1 Person Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title  |  | Forename and any middle names |  | Other names person prefers to be known as  |  |
| Surname (family name) |  |
| AddressPostcode |  |
| Telephone  (✓preferred) | Landline |  | Mobile |  |
| NHS number  |  | Date of Birth |  | Gender |  |

## A.2 Main Carer Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title  |  | Forename |  | Surname |  |
| AddressPostcode  |  |
| Telephone(✓preferred) | Landline |  | Mobile |  |

## A.3 Details of General Medical Practitioner or GMP

|  |  |  |  |
| --- | --- | --- | --- |
| GP’s name |  | Practice telephone number |  |
| AddressPostcode |  |

**A.4 Additional needs - Communication please tick all which apply to the person**

Please append additional information if this does not allow you to describe fully the person’s needs

|  |  |  |
| --- | --- | --- |
| Communication Needs | **Yes** ❑**No** ❑ | Please provide any other ways you use to communicate with the person: |

**Verbal communication**:

Please indicate which of the following best describes the level of verbal communication:

Full ability to verbally communicate ❑ Uses occasional words ❑
Uses short sentences ❑ Does not use verbal communication ❑

Does the person have any communication or information needs? Yes ❑ No ❑

Is Accessible Information required? ❑

What can be provided to support communication?

Large print❑Easy Read❑ Braille❑ BSL❑

Other

**Language needs** – Is an Interpreter needed? Yes ❑ No ❑

If yes which language?

## A.5 Additional needs - Mobility please tick all which apply to the person

|  |  |  |  |
| --- | --- | --- | --- |
| Able to leave home for healthcare appointmentsRequires an escort/ assistance to attend Current method of transport: Own vehicle ❑Taxi ❑ Public transport ❑Hospital transport ❑ Confined to home Bed Bound  | ❑❑❑❑ | Wheelchair user The wheelchair is larger than a standard wheelchairCan transfer from wheelchair to dental chair  Requires an aid to transfer e.g. hoist/ stand aid/ transfer boardPlease tell us further information here:  | ❑❑❑❑ |
|  |  |  |  |

## A.6 Main reason for referral Tick (✓) all which apply

Learning disability ❑ Autistic spectrum disorder ❑ Mental Health Condition ❑

Medical disability ❑ Dementia❑ Bariatric person ❑ Weight if over 19 Stone ❑

Physical disability ❑ Extreme dental phobia ❑Other (detail below) ❑

|  |
| --- |
| Other– please describe |

|  |  |
| --- | --- |
| List main medical conditionsAllergies | List medications (continue on separate sheet) |

**Part B: Information about the Person’s Oral Health**

## B.1 Why are you seeking our help?

|  |  |
| --- | --- |
| Why does this referral need to be made to us rather than seeing a general dentist? |  |
| How long ago did the person last see a dentist? |  |
| Name of dentist and dental surgery if known: |  |
| Are they taking any medication for a dental problem?(please list) |  |

**What concerns do you have about the person’s mouth?** Please tick all which apply

Do you think the person is in pain (give details below)? Yes ❑ No ❑

Tooth Problem ❑ Gum Problem ❑ Sore Mouth ❑

Swelling ❑ Ulcers ❑ Bad Breath ❑

Lost denture(s) ❑ Broken denture(s) ❑ Denture(s) not fitting ❑

Lost Crown ❑

|  |
| --- |
| Other– please tell us here |

 Are you attaching additional information, e.g. letters, reports Yes ❑ No ❑
(attach supporting information if needed)

## B.2 Details of person making referral

|  |  |
| --- | --- |
| Name of person making referral  |  |
| Relationship to person/job title  |  |
| Addressand Postcode  |  |
| Telephone (✓preferred) | Landline |  | Mobile |  |
| Signature of person making referral  |  | Date  |  |

Please tick to confirm you have told the person (and/or relatives, carer where appropriate) you are making this referral ❑

Please tick to confirm this referral complies with the General Data Protection Regulation, so that information can be shared with other Health and Social Care Professionals if this is necessary and in the Person’s Best Interest ❑

**Unless exempt, NHS charges for dental treatment will apply. For further information on dental charges please see the following information:**

https://www.nhs.uk/nhs-services/dentists/dental-costs/understanding-nhs-dental-charges/

**Please send this completed form to**

Solent NHS Trust Dental Single Point of Access,

Level A, Royal South Hants Hospital, Brinton’s Terrace, SOUTHAMPTON SO14 0YG

**Tel:** 0300 300 2014 Option 3

**E-mail**: SNHS.CentralPointofReferral@nhs.net

**Please keep a copy for your records.**

|  |  |  |
| --- | --- | --- |
| For admin use only  | Date received …/…/… | Referral Accepted Yes / No  |
| Wait list clock startedOn …/…/… | Date of appointment On …/…/…… | Dealt with bySignature. ………………………  |