Please read guidance notes before completing this form

# Part A About the Patient

# A.1 Patient Details

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  | Forename and any middle names | |  | | | | Surname (family name) | |  | |
| Address  Postcode |  | | | | | | | | | | |
| Telephone (✓preferred) | Landline |  | | | | Mobile |  | | | | |
| NHS number |  | | Date of Birth | |  | | | | Gender | |  |

## A.2 Main Carer Details

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  | | Forename |  | | | Surname |  | |
| Address  Postcode |  | | | | | | | | |
| Telephone (✓preferred) | Landline |  | | | Mobile |  | | | |
| Name of person/s with parental responsibility and relationship |  | | | | | | | |

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

|  |  |  |  |
| --- | --- | --- | --- |
| GP’s name |  | Practice telephone number |  |
| Address  Postcode |  | | |

## A.4 Main reason for referral Tick (✓) all which apply - see published acceptance criteria

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Learning disability | ❑ | Medical disability | ❑ | Dental defects | ❑ | Extensive Tooth Decay | | ❑ |
| Autistic spectrum disorder | ❑ | Physical disability | ❑ | Pre/unco-operative | ❑ | Congenital and developmental conditions | | ❑ |
| Mental Health Condition | ❑ |  |  | Weight | | | Other  (detail below) | ❑ |

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

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

**A.5 Additional needs - Communication please tick all which apply to the patient**

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

**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 patient 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.6 Additional needs - Mobility please tick all which apply to the patient

|  |  |  |  |
| --- | --- | --- | --- |
| Walks unaided | ❑ | Wheelchair user | ❑ |
| Walks with an aid (e.g. walking stick/frame) | ❑ | Can transfer from wheelchair to dental chair | ❑ |
| Able to leave home if transport is available | ❑ | Unable to transfer from wheelchair unaided to dental chair - needs assistance (e.g. hoist) | ❑ |
| Confined to home (needs home visit) | ❑ |
| Needs assistance (e.g. hoist / stand aid / wheelchair recliner) or other needs - please tell us here:  (attach supporting information if needed) | | | |

# Part B: Please answer all questions.

## B.1 Dental problems about the patient

|  |  |
| --- | --- |
| Why does this referral need to be made to us rather than the child seeing a general dentist? |  |
| How long ago did the patient last see a dentist? |  |
| Are they taking any medication for a dental problem? (please list) |  |

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

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

Problem Teeth ❑ Problem Gums - ❑ Sore Mouth ❑ Swelling ❑ Ulcers ❑

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 patient/job title | |  | | | |
| Work Address and Postcode |  | | | | |
| Work Telephone  (✓preferred) | Landline |  | Mobile | |  |
| Signature of person making referral |  | | Date |  | |

Please tick to confirm you have told the patient (and/or guardian if <16 years old) 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 Patient’s Best Interest ❑

**Family, carers, social and non-dental health care professionals - 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 **E-mail**: [centralpointofreferral@solent.nhs.uk](mailto:centralpointofreferral@solent.nhs.uk)

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