

## Paediatric Dental Department Referral Pro-forma

1. PATIENT DETAILS

All referrers are requested to provide the information required on Pages 1-3 of this pro forma. Inappropriate or incomplete referrals will be returned outlining the reason(s) for the return.

Referral date

Title	Surname	Forename		M/F	Date of Birth	Age	Interpreter required Yes / No		
Address					Mobile no				
				Telephone no					
Post code				H&C no					
Has the person with parental responsibility provided con					sent for this referral? Yes / No				
If patient is attending with a care worker or guardian, please provide details:									
Name				Contact number					
Address (if different to above):									
2.	2. REFERRING DENTIST GDP		□ CDO / SDO						
GDP name			CDO/SDO name						
Practice address			CDS Clinic address						
Destands			Postcode						
Postcode Email address									
			Email address Telephone no						
Telepho	ne no			i eleph	one no				
3. REASON FOR REFEERRAL									
Please i	ndicate the specific rea	ason for the re	ferral of this	patient	to the Paediatric	c Dental	Department by selecting one		
Please indicate the specific reason for the referral of this patient to the Paediatric Dental Department by selecting one or more from the referral criteria below:									
Treatment under General Anaesthetic (GA) (select referral reason from list below)									
Please confirm as the referring dentist by answering YES that all possible alternative options for treatment provision, pain relief and anxiety									
management, along with the risks involved with GA, have been discussed with this patient / parent / guardian prior to making this referral.									
This referral will not be accepted for GA treatment without a YES answer being provided here.									
CARIES				NON CARIOUS TOOTH SURFACE LOSS					
PAIN			ENAMEL/DENTINE DEFECTS						
INFECTION			DENTAL ANOMALIES						
SWELLING			☐ HYPODONTIA						
MULTIPLE EXTRACTIONS (<3YS OLD)				SUPERNUMERARIES					
MULTIPLE EXTRACTIONS (COMPLICATING PMH)				DISORDERS OF ERUPTION / EXFOLIATION					
BEHAVIOURAL ISSUES			COMPLEX EXTNS (PROVIDE DETAILS & RADIOGRAPHS)						
LEARNING DISABILITY				HARD TISSUE PATHOLOGY					
PROMINENT GAG REFEX			SOFT TISSUE PATHOLOGY						
DENTOALVEOLAR TRAUMA			TMJ RELATED ISSUES						
COMPLEX ENDODONTICS (OPEN APEX)			F	PARAFUNCTIONAL	HABITS				
OTHER									

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Please indicate the treatment required on the dental chart below								
X for the teeth / roots to be extracted R for teeth to be restored E for endodontics								
PERMANENT DENTITION								
8     7     6     5     4     3     2     1     1       8     7     6     5     4     3     2     1     1	2     3     4     5     6     7     8       2     3     4     5     6     7     8							
PRIMARY DENTITION								
E D C B A A	B C D E							
Summary of treatment being requested and any other relevant clinical information								
	Please state what attempts have been made to treat the child in primary care.							
months? Yes / No	Please indicate a referral grading Routine / Urgent							
Antibiotic name(s)	se outline reason for urgent referrals:							
Have radiographs been included? Yes / No OF	PA(s) Bitewings DPT							
If radiographs are not included for referrals for tooth/hard tissue pathology/anomalies, including caries, please outline reason(s)								
Please confirm by answering YES that preventive advice and continuing care will be offered to the patient irrespective of the referral.								



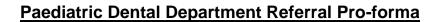


This referral will not be accepted without a YES answer being provided here.								
4. MEDICAL HISTORY DO NOT SEND A	A BLANK FORM – STATE NONE IF NECESSARY							
GP Name Telephor	ne no Cypher No.							
GP Address								
Postcode								
Please indicate if the patient has/has had/ suffers from								
☐ NONE OF THE BELOW	EPILEPSY							
☐ HEART MURMUR NOT DIAGNOSED AS INNOCENT	FAINTS							
CONGENITAL HEART DEFECT	☐ NEUROMUSCULAR DISORDER							
ASTHMA / BRONCHITIS / CHEST COMPLAINT	SKIN PROBLEMS							
ENT PROBLEM	MUSCULOSKELETAL DISORDER							
BLOOD OR BLEEDING PROBLEM	OBESITY							
INFECTIOUS DISEASE (EG HEPATITIS)	BEHAVIOURAL DISORDER							
LIVER DISEASE	AUTISM / ADHD							
KIDNEY PROBLEM	LEARNING DISABILITY							
ANAEMIA	☐ VISUAL IMPAIRMENT							
ONCOLOGY DIAGNOSIS	COMMUNICATION IMPAIRMENT							
DIABETES	SYNDROME							
OTHER ENDOCRINE DISORDER	ALLERGY (SEE BELOW)							
OTHER								
Please provide details on any of the above, outlining	g the severity of the condition listed above and any possible impact							
on delivery of care								
Please provide details of any known allergies	Please provide details of current prescribed medications							
The second of th								
If currently or previously under hospital care, please	e state   Mobility issues							
name of paediatrician and hospital attended	☐ Walks unaided							
	☐ Walks aided							
	☐ Wheelchair user							
	Language issues							
	Is an Interpreter required Yes							
	Specify Language							

All referrals to Belfast Trust, Paediatric Dental Department can be posted or emailed.

## Postal address:

Paediatric Dental Department, Royal Belfast Hospital for Sick Children,





Falls Road Belfast BT12 6BA

Landline: 02890 632048 Email address: paeddentalreferral@belfasttrust.hscni.net