Belfast Health and Social Care Trust
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Paediatric Dental Department Referral Pro-forma

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.

1. PATIENT DETAILS			**Referral date**			
Title	Surname	Forename	M / F	Date of Birth	Age	Interpreter required Yes / No
Address Post code			Mobile no Telephone no H&C no			
Has the person with parental responsibility provided consent 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. REFERRING DENTIST	☐ GDP ☐ CDO / SDO
GDP name Practice address Postcode Email address	CDO/SDO name CDS Clinic address Postcode Email address
Telephone no	Telephone no

3. REASON FOR REFEERRAL	
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. YES** ☐	
☐ 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)	☐ 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	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

PRIMARY DENTITION

E	D	C	B	A	A	B	C	D	E
E	D	C	B	A	A	B	C	D	E

Summary of treatment being requested and any other relevant clinical information

Please describe previous dental history including experience with LA

Please state what attempts have been made to treat the child in primary care.

Has the patient been prescribed antibiotics in the past 3 months? Yes / No

Antibiotic name(s)

Please indicate a referral grading Routine / Urgent

Please outline reason for urgent referrals:

Have radiographs been included? Yes / No ☐ IOPA(s) ☐ Bitewings ☐ OPT

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.

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This referral will not be accepted without a YES answer being provided here.	YES ☐

4. MEDICAL HISTORY

DO NOT SEND A BLANK FORM – STATE NONE IF NECESSARY

GP Name	Telephone no	Cypher No.

GP Address

Postcode

Please indicate if the patient has/has had/ suffers from

- ☐ NONE OF THE BELOW
- ☐ HEART MURMUR NOT DIAGNOSED AS INNOCENT
- ☐ CONGENITAL HEART DEFECT
- ☐ ASTHMA / BRONCHITIS / CHEST COMPLAINT
- ☐ ENT PROBLEM
- ☐ BLOOD OR BLEEDING PROBLEM
- ☐ INFECTIOUS DISEASE (EG HEPATITIS)
- ☐ LIVER DISEASE
- ☐ KIDNEY PROBLEM
- ☐ ANAEMIA
- ☐ ONCOLOGY DIAGNOSIS
- ☐ DIABETES
- ☐ OTHER ENDOCRINE DISORDER
- ☐ OTHER
- ☐ EPILEPSY
- ☐ FAINTS
- ☐ NEUROMUSCULAR DISORDER
- ☐ SKIN PROBLEMS
- ☐ MUSCULOSKELETAL DISORDER
- ☐ OBESITY
- ☐ BEHAVIOURAL DISORDER
- ☐ AUTISM / ADHD
- ☐ LEARNING DISABILITY
- ☐ VISUAL IMPAIRMENT
- ☐ COMMUNICATION IMPAIRMENT
- ☐ SYNDROME
- ☐ ALLERGY (SEE BELOW)

Please provide details on any of the above, outlining 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
If currently or previously under hospital care, please state name of paediatrician and hospital attended	**Mobility issues** ☐ 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,

Paediatric Dental Department Referral Pro-forma

Falls Road
Belfast
BT12 6BA
Landline: 02890 632048

Email address: paeddentalreferral@belfasttrust.hscni.net