**Community Dental Service**

**Child Referral Form**

**To be completed by HEALTH & SOCIAL CARE PROFESSIONALS**

**This referral form is for:**

* Children under 18 years

**BCUHB Community Dental Service (CDS) does not accept self-referrals.**

* Children who meet the CDS criteria must be referred by Healthcare / Social Care Professionals.
* Patients are allocated to the most appropriate clinic for their needs, which may not necessarily be geographically the closest one.

**To submit a referral:**

* Please refer to our Referral Guidelines to ensure the referral is appropriate for the remit of our service.
* Complete the form in full, as failure to do so will delay the referral process.
* Return the completed form as a PDF document via email to [*BCU.NWCDSReferralsTeamCentral@wales.nhs.uk*](mailto:BCU.NWCDSReferralsTeamCentral@wales.nhs.uk)for triage.
* Complete one form per child.

Thank you,

**CDS Referral Team**

**If you have any queries about Community Dental Service referrals, please contact our help desk** email: [*BCU.NWCDSReferralsTeamCentral@wales.nhs.uk*](mailto:BCU.NWCDSReferralsTeamCentral@wales.nhs.uk)

**Criteria for CHILD referral, please tick all which apply**

**Medically Compromised or Complex** - Patients with very complex medical conditions which put the patient at significant risk of adverse events and require dental care within a community setting. Patients whose dental management requires close liaison with medical specialties.

**Moderate to Severe Learning Disability**- Patients who require high level of support and or care for their daily activities, including dental visits.

**Physical Disabilities**- Patients whose mobility / physical disability requires specialist facilities and / or skills to manage their oral care i.e. hoists, wheelchair recliners.

**Mental Health Problems** - Patients diagnosed with mental health problems **for** **whom there is evidence** that they cannot be treated in a general practice setting, and require additional skills. Patients may receive limited/single course of treatment and be discharged from the service.

**Dental Anxiety and Phobia**- Patients **for whom there is evidence** that they have a dental phobia and / or anxiety which affects their ability to receive dental treatment with a GDP. Patients will receive one course of treatment and will be discharged. A re-referral can be submitted as required.

**Cognitive Impairments**- Patients with significant cognitive impairments.

**Significant Vulnerable Groups**- Assessed on an individual basis

**Patients exceeding GDP chair weight limits. -** Patients will currently only be accepted up to 25 stone / 158 kg. Please include a patient’s weight in the referral.

**Bariatric Patients -** This service currently has no infrastructure to support these patients. For patients 25 stone / 158 kg and above, please email the referral team for advice.

**Looked After Child / Child on Care and Support Plan or Care and Support Protection Plan -** Referrers in these cases will be expected to be proactive in ensuring attendance.

**Other Dental Anomalies -** Significant dental anomalies and developmental defects.

**Pre Co-operative Children -** Where a concern has been identified.

**Complex Paediatric Trauma**

**Child Patient Details**

**Child Name** Click or tap here to enter text.

**NHS Number**  Click or tap here to enter text.

**Date of Birth** Click or tap here to enter text.

**Address** Click or tap here to enter text.

**Postcode** Click or tap here to enter text.

**Contact Telephone Number**  Click or tap here to enter text.

**Parent/Legal Guardian/Carer**

**Relationship to Child** Click or tap here to enter text.

**Name** Click or tap here to enter text.

**Preferred Telephone Number** Click or tap here to enter text.

**Alternative Telephone Number**  Click or tap here to enter text.

**Address** Click or tap here to enter text.

**Email Address**  Click or tap here to enter text.

**Other Contacts**

**Name of School (if appropriate)** Click or tap here to enter text.

**Health Visitor/ School Nurse**  Click or tap here to enter text.

**General Medical Practice Details** Click or tap here to enter text.

**Other Key Contacts**  Click or tap here to enter text.

**Dental Information**

**Is the patient currently experiencing pain**?

YES

NO

Unsure

If Yes, please provide comments:

Click or tap here to enter text.

**Do they have a history of oral or facial swelling or infection?**

YES

NO

If yes, please specify

Click or tap here to enter text.

**Are there any other dental concerns for this patient?**

YES

NO

If yes, please provide as much detail as possible

Click or tap here to enter text.

**Medical Information**

**Does the patient have any medical conditions?**

YES

NO

If yes, please provide as much detail as possible

Click or tap here to enter text.

**Is the patient on any medication?**

YES

NO

If yes, please list here

Click or tap here to enter text.

**If you have access to patient medical records, please attach the standard patient medical summary form containing core medical information and repeat medication lists.**

**Does the patient have any allergies?**

YES

NO

If yes, please provide details:

Click or tap here to enter text.

**Patients Weight** Click or tap here to enter text.

**Patients Height** Click or tap here to enter text.

**Additional Needs & Requirements**

**Travel & Transport - How will they travel to the clinic?**

Patient Transport Service (Welsh Ambulance Services Trust)

Private transport

Public Transport

Other

Click or tap here to enter text.

**What are the patients mobility needs?**

Walks unaided

Walks with aids

Wheelchair user who can self-transfer

Unable to transfer to dental chair without equipment required

**Please state equipment required** eg. Hoist

Click or tap here to enter text.

**Are there any communication barriers?**

Hearing impairment

Visual impairment

Other

Please provide details:

Click or tap here to enter text.

**Is an interpreter required?**

YES

NO

If yes, please provide details:

Click or tap here to enter text.

**Who has parental responsibility?**

If this is not the parent, we require copies of any orders in place. This can be brought to the appointment or attached to this referral. Without this we cannot proceed with any necessary treatment.

Click or tap here to enter text.

**Does the child have a social worker or similar support professional?**

If YES, please provide name and contact details including telephone and email address.

Click or tap here to enter text.

**Is the child supported by any of the following?** Please tick all that apply

Care and Support Plan

Care and Support Protection Plan

Public Law Outline

Looked After Child

Not applicable

**If the child is supported by a Care and Support Protection Plan, please provide the category of harm.**

Physical Abuse

Psychological Abuse

Neglect

Sexual Abuse

**Who does the child currently live with?** Please tick all that apply

Own Parent

Extended Family

Connected Carer

Foster Carer

Residential Care

Adoptive Placement

Other

Click or tap here to enter text.

**Any legal order in place?** Please tick all that apply

Interim Care Order

Full Care Order

Placement Order

Special Guardianship Order

Child Arrangement Order

Not applicable

**Is there any further information you feel we should know in order for us to help this patient?**

Including but not limited to:

* Certain family circumstances or sensitive information
* Anyone we should not discuss this referral with who may present a risk to the patient and / or carer
* Anyone who would pose a risk to the staff within our service?
* One or more carers required
* Accompanying family member
* Separate or private waiting area required
* Patient best arriving direct into surgery /bypassing waiting area

Click or tap here to enter text.

**Social History**

**History of substance misuse**

YES(current)

YES (previous)

NO

Unknown

Please provide details:

Click or tap here to enter text.

**Known history of challenging / intimidating or inappropriate behaviours.**

YES

NO

If yes, please provide details.

Click or tap here to enter text.

**Referrers Details**

**Name**  Click or tap here to enter text.

**Job Title** Click or tap here to enter text.

**Work Address** Click or tap here to enter text.

**Telephone Contact Number** Click or tap here to enter text.

**Email Address** Click or tap here to enter text.

**Thank you for completing the form**

Please now save this form as PDF document and return via email to [*BCU.NWCDSReferralsTeamCentral@wales.nhs.uk*](mailto:BCU.NWCDSReferralsTeamCentral@wales.nhs.uk)for triage.

**How to save a Word document as a PDF**

* Go to File
* Select ‘Save As’
* Select ‘Save as Type’
* Select PDF
* Save document

Please provide / attach any additional documentation as relevant/available e.g. photographs, radiographs, MAR charts, list of medication.