

Special Care Dental Service – Request for assessment

NOTE: PLEASE ENSURE A CURRENT TREATMENT PLAN AND ALL RELEVANT X-RAYS ARE ENCLOSED WITH THIS REQUEST FOR ASSESSMENT FORM. Please send/email referrals to;

**SOUTH DEVON SPECIAL CARE DENTAL SERVICE,
CASTLE CIRCUS HEALTH CENTRE, ABBEY ROAD, TORQUAY, TQ2 5YH
Email – sdc-dental.t-sd@nhs.net**

Patient's details: (PRINT)			
Patient's Name			
Patient's Title	Mr / Master / Mrs / Miss / Ms	Sex	Male / Female
Home address			
Postcode			
Contact Telephone Number		Mobile Number	
Date of Birth		NHS Number	
Patient's Doctor's Name		Doctors Surgery	

Name of Referrer (PRINT)	
Name of Referring Surgery	
Surgery Address & Postcode (surgery stamp can be used)	
Referrer Telephone Number	
Practice Email Address (NHS mail wherever possible)	
Date patient last seen	

Please tick reason for referral to Special Care Dental Service:

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|---|-----|--------------------------------|-----|
| Learning disability | [] | Acquired brain injuries | [] |
| Diagnosed mental health illness | [] | Autistic spectrum disorders | [] |
| Current significant misuse of substances | [] | Child with cleft lip or palate | [] |
| Dental treatment complicated by medical condition | [] | | |
| Medical condition significantly affected by poor oral health | [] | | |
| Sensory disability making access to general dental service difficult | [] | | |
| Physical disability making access to general dental service difficult | [] | | |
| Wheelchair user unable to transfer to dental chair (wheelchair platform required) | [] | | |
| Access to bariatric chair needed | [] | | |
| Uncooperative preschool children, children with a high level of anxiety or children with a phobia of dental treatment (treatment must have been attempted in GDP first) | [] | | |

Please give information explaining chosen category:

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Dental Treatment plan for patient: Please attach Personal Dental Treatment plan form FP17DC

Carious teeth —+— —+—	
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Outline of recent dental history / treatment attempted:

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CHECKLIST Please ensure the following is enclosed / agreed:

- Recent relevant X-ray emailed to sd-dental.t-sd@nhs.net (from NHS email account) []
- Signed Special Care Dental Service medical history form enclosed []
- Personal Dental Treatment plan form FP17DC enclosed []
- Patient has been informed of request for assessment and the reason for referral []
- Referral is made in line with Delivering Better Oral Health, GDC Standards and is in the patient's best interest []
- We will devise the patient's final treatment plan, do you wish to be informed of these changes before we proceed?
(please note if yes this may delay the patients treatment) Yes [] No []
- Do you consider this to be an urgent referral? If yes please state why: Yes [] No []

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PLEASE NOTE:

The Special Care Dental Service in Torbay does not carry out conservation of children's teeth under GA and, in line with the guidance from the British Society of Paediatric Dentistry, it should be explained to carers of all referred children that undergoing a GA would usually indicate radical extractions of teeth as necessary so that further GA's may be prevented in the future.

Date of referral	
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The Special Care Dental Service reserves the right to refer patients back to their General Dental Practitioner if they do not fit any of the criteria the service is commissioned to provide, or if the form is not legible or completed fully.

Signature of referrer	
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