**Domiciliary Dental Service Referral Form**

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| **Residents details**  **Full Name ......................................................................................................................**  **Date of Birth .....................................................................................................................**  **Contact Telephone no. ........................................................................................................**  **Care Home Address .................................................................................................................**  **................................................................................................................**    ......................................................................................................................    **Post code** ...................................................................................................................... |
| **Doctors Name and address:** |
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| **Doctors Telephone No**. |

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| **Referred by:** |
| Full Name: Position |
| Date of referral: |
| Signature: |
| **Reason for referral** -please give as much details as possible including time scale  Please circle  Pain upper -lower / left / right/ bleeding gums / chipped tooth  Swellin - upper / lower /l eft / right  Lost dentures / ill fitting -upper / lower  Ulcers – upper / lower / left / right  Dental Examination  Other –  **Height ………………….. Weight………………….** |

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| **Medical History included: YES NO**  **Please confirm the resident’s medical history has been included** |
| **Mars chart included: YES NO**  **Please confirm the resident’s medical history has been included** |
| **Does the resident pay for their NHS dental treatment- YES**  **If not, what is the resident receiving to make them exempt?**  **Please confirm the exemption** |
| **Is the resident able to make his/her own decisions?**  **or, is their family member/ representative involved in these decisions?**  **Please give details**  **NAME………………………… Contact number………………………….**  **if so does the family member or representative know of this referral?**  **YES NO** |

Please note if a resident pays for their NHS dental treatment, full payment is to be made on the day of the appointment.

If this referral form is not completed correctly with all the information we have requested we will return the form and will await a completed form.

Please note for NHS dentures we have a waiting list- please inform resident and family members or representative of this

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| Office use only |  |  |
| URGENT | NONE URGENT |  |
| AREA |  |  |
| DENTURES |  |  |
| ALL INFORMATION AS REQUESTED | NOT ALL INFORMATION AS REQUESTED | DATE RETURNED |