Nottinghamshire Healthcare
NHS Foundation Trust

Referral to Nottinghamshire Salaried Dental Service

Patient Name:	Referrer Name:
Title Date of Birth:	Job Title:
Gender: Male ⊙ Female ○	Practice Name:
Address:	Address:
Post Code:	Post Code:
Tel No: Home	Tel No:
Mobile	

Is the patient exempt from NHS dental Charges: Yes ⊙ No ○
If **YES**, which exemption?_____

Reason For Referral (Please tick one of the following)

Child (Special Care)	⊙
Medically Compromised	○
Adult/Child with learning difficulty	○
Adult Mental Health (under mental health care team)	○
Child Behavioural/Anxiety (single course of treatment)	
Either: Inhalation Sedation	○
Or: GA	○
Domiciliary Care	○

GP Name:

Address:

Post Code:

Tel No:

Reason why you believe this patient cannot be treated in general dental practice:

Previous dental history (including treatment with local anaesthetic, sedation, GA, hypnosis, treatment attempted etc).

Prevention/Acclimatisation	Fillings without LA	Fillings with LA
Extraction with LA	Treatment with RA/IV Sedation	Previous referral to SDS

Date of bitewings last taken: _____

Comments:

Treatment Requested:

To be restored: _____ To be extracted: _____

Radiographs sent Type _____

positive about integrated healthcare

Medical history including details of current medication:

Is the patient's weight above 22 stone (139kg)?: Yes ⊙ No ○

Special requirements to support delivery of dental care (e.g. wheelchair user unable to transfer to dental chair):

Is an interpreter required: Yes ⊙ No ○ (The need for an interpreter will not be accepted as a sole reason for referral)

Language required: _____

Referrer Declaration (Tick to indicate agreement)

I have explained to the patient and/or parent/carer that I am referring them to the NSDS for the reason/treatment detailed above.

(For dentist referrals only) I have discussed alternative methods of treatment, i.e. LA/RA/GA and pain control.

For patients referred who lack the capacity to make treatment decisions, please inform them to attend with an informed representative.

(For dentist referrals only) I have explained that the treatment provided on referral is a separate course of care and as such may incur further NHS charges where appropriate.

The patient and/or parent/legal guardian has agreed to this referral.

Signature of Referrer: _____ Date:

The patient assessment will be based upon the information provided. This may mean that the patient will be asked to attend a clinic some distance from their home. Please could you advise them of this fact.

You are advised to keep a copy of this referral.

Completed forms should be emailed to: not-tr.nottinghamspecialneedsdentalreferrals@nhs.net

For any queries please phone: 01159935540

Office Use Only

Referral Number_____ Date received at clinic: _____

Triaged by: _____Date: _____

Ref to Senior Clinician for decision, if required. Name: _____Date: _____

Accept:

Appointment type: Clinic Location:

To be seen by _____

Reason Criteria not met: