DOMICILIARY REFERRAL FORM FOR SURREY COMMUNITY DENTAL SERVICE

Please use Surrey Community Dental Referral criteria and Guidance Sheets to assist with your referral.

Email completed forms via NHS email (from NHS email accounts only) to:

Vcl.communitydentalservices@nhs.net OR post to the following address:

Surrey Community Dental Referral and Triage Centre, Buryfields Clinic, 61 Buryfields Rd, Guildford, GU2 4AX

Please be advised that the full range of dental services available in our dental clinics cannot be provided on a domiciliary basis. The dental care that we can provide on these visits is therefore extremely limited and patients should attend a dental surgery for treatment wherever possible.
Where it is not possible to carry out a certain procedure in the home, it may be necessary for the patient to attend one of our clinics or a hospital for treatment.

The responsibility for transportation to the relevant location for dental treatment is the responsibility of the patient's General Medical Practitioner. We are not able to arrange transportation for patients.

WE ARE ONLY ABLE TO ACCEPT REFERRALS FOR DOMICILLARY CARE FOR PATIENTS WHO HAVE BEEN CONFIRMED HOUSEBOUND BY THEIR GENERAL MEDICAL PRACTITIONER.

Please complete all sections. Incomplete referral forms will be returned.

Section 1. PATIENT DETAILS:			
Last Name:	First Name:		Title:
Date of Birth:	Age:	NHS No.	
Address: Post Code:		Home Tel No: Mobile/daytime Tel No:	
Section 2. GMP DETAILS:			
GMP's Name: Practice Address: Post Code:		GMP's Surgery Stamp:	
Section 3. CARER DETAILS (If applicable):			
Name & Address: Relationship to Patient: Tel No: Mobile No:			
Section 4. SIGNIFICANT MEDICAL HISTORY:			
Please include a printed Summary of Medical History **Allergies:** **Medications:** **Social/family history:**			

Section 5. DENTAL REFERRAL DETAILS:

Please detail the reason for referral into the Surrey Community Dental Service and treatment required (if known):

Please include details of investigation or referrals to other departments, X-rays or any other relevant information.

Section 6. DOMICILIARY REFERRAL DETAILS

Please detail why the patient requires domiciliary dental care:

Section 7. EXEMPTION DETAILS

Is the Patient Exempt: Yes □ **No** □

You will be asked to show proof of your entitlement to help with dental costs. If you are not sure you are entitled to help, then you must pay. You can claim a refund, but make sure you keep all receipts.

If you are exempt and you have a HC2 or HC3 certificate, please enter the certificate number below

□ Full remission HC2 Certificate Certificate Number:_____

□ Partial Remission HC3 Certificate Certificate Number:_____

Section 8: Signatures

Referrer

I confirm that the details enclosed are correct to the best of my knowledge. I confirm that the patient is housebound and therefore can only access treatment by domiciliary care.
I understand that should the patient be accepted for treatment that this will be for a single course of treatment.

Signed…….. Dated……

Print name……..

Patient

I agree to the referral to the Surrey Community Dental Service as explained to me by the referrer

Signed…….. Dated……

Print name……..