REFERRAL FORM FOR SURREY COMMUNITY DENTAL SERVICE

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

Referrals for Domiciliary care will only be accepted by GMP referral – use separate Domiciliary Referral Form

Email completed forms (from NHS email accounts only) to:Vcl.communitydentalservices@nhs.net

OR Post to the following address: Surrey Community Dental Referral & Triage Centre Buryfields Clinic, 61 Buryfields Rd, Guildford, GU2 4AX

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: Postcode:

Section 3. REFERRER DETAILS:
GDP □ GMP □ Care Homes □ Support Worker □ School Nurses □ Social Care Practitioners □ Name of Referrer: Practice Name & Address: Postcode: Tel No: Email:

Section 4. CARER DETAILS (If applicable):
Applicable? Yes/No Name & Address: Relationship to Patient: Tel No: Mobile No:

Section 5. SIGNIFICANT MEDICAL HISTORY:
If referring from GP please include a printed Summary of Medical History Allergies: Medications: Relevant Social or Family History:

Section 6. REFERRAL DETAILS:

Why is referral into the Surrey Community Dental Service Required?

Section 7. CURRENT DENTAL HISTORY:

Please include details of Investigation, X-rays or Referrals to other departments.

Radiographs Enclosed: Yes/No **If No please state why**:

PA □ Bitewings □ DPT □ Occlusal □

History of present complaint and any treatment already undertaken:

Please outline treatment attempted and why it was unsuccessful:

If the referral is with regard to orthodontic extractions, an opinion letter from the Orthodontist specifying the extractions must be included with the referral

Section 8. APPOINTMENT REQUIREMENTS:

Interpreter Required?	**Yes/No**	Language: _____	
Is the Patient a Wheelchair user?	**Yes/No**	Is GA required?	**Yes/No**
Does the patient require a hoist	**Yes/No**	Is Inhalation Sedation required?	**Yes/No**

Section 9. 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 10. SIGNATURES:

Referrer

I confirm that the details enclosed are correct to the best of my knowledge. I understand that should the patient be accepted for treatment that this will be for a single course of treatment. I will provide continuing care following discharge from the Surrey Community Dental Service.

Signed…….. **Dated…….**

Print name……...

Patient

I the Patient/Parent/Carer (delete as applicable) agree to the referral to the Surrey Community Dental Service as explained to me by the referrer

Signed…….. **Dated…….**

Print Name……..