GUIDANCE NOTES FOR REFERRAL TO INDIVIDUAL DEPARTMENTS

- **PLEASE READ THESE GUIDANCE NOTES CAREFULLY TO ENSURE APPROPRIATE AND SUCCESSFUL REFERRAL OF YOUR PATIENT**
- **PLEASE FILL IN SECTIONS A, G AND I FOR ALL PATIENTS**
- **PLEASE FILL IN ONE SECTION IN B – F or H USING THIS GUIDANCE**

1. PAEDIATRIC DENTISTRY – Fill in Sections A, B G and I

The Department of Paediatric Dentistry (Child Dental Health) has seen an enormous increase in the number of referrals over the last five years. In order to maximise the appropriate use of the specialist facilities in the Department, the following guidelines should apply:-

1. Trauma

Advice about the immediate management of trauma can be accessed through the Department. Call and ask for the Duty Consultant. For urgent appointments for trauma patients please contact the department by telephone (see Contact Details page).

Children with dento-alveolar trauma should be referred as a matter of urgency. Trauma patients may be required to be kept under review for prolonged periods, but please note only their traumatic injuries will be monitored and treated. Regular recall to Primary Care must continue.

In section F give details of the injuries sustained, including timing and any treatment undertaken to date. Please include any relevant radiographs, including pre-trauma.

2. Molar/Incisor Hypomineralisation

Children with hypomineralised or hypoplastic teeth will be accepted as referrals although advice, rather than treatment may be offered. Where treatment is undertaken, it will be limited to those teeth which have been diagnosed as hypoplastic/hypomineralised. **In section F indicate which teeth are affected and what treatment has already been completed.**

3. Tooth Discolouration

Patients with intrinsic and extrinsic tooth discolouration e.g. fluorosis, internal resorption, etc, will be accepted as referrals. **In section F indicate which teeth are affected and what treatment has already been completed.**

4. Development defects

Referral of patients with dental anomalies, developmental defects such as amelogenesis imperfecta, hypodontia, supernumerary teeth etc, are encouraged. **In section F indicate which teeth are affected and what treatment has already been completed.**

5. Non-Carious Tooth Surface Loss

Referrals for patients with attrition/erosion will be accepted either for advice only or for assessment/treatment when that treatment requires the specialist skills of a paediatric dentist. Provision of study models is requested to help establish the rate of progression in cases of non-carious tooth surface loss. **In section F indicate which teeth are affected and what treatment has already been completed.**

6. Soft Tissue Disorders

Soft tissue disorders such as ulceration, infection, papillomas, mucocoeles etc are accepted as referrals. There is a joint Paediatric/Oral Medicine clinic on the first Monday of every month where children with soft tissue pathology can be seen. For urgent appointments call the department (see Contact details page) and ask for the Duty Consultant.

7. Medically Compromised Patients

Referrals on the grounds of medical compromise should be made to the Dental Hospital, rather than RHSC (Yorkhill) in the first instance. Exceptions to this may be patients who are actively undergoing treatment at RHSC (Yorkhill) at the time of referral. Regular recall to primary care for prevention should continue to ensure patients are not de-registered. Children with mild medical compromise should be managed in primary care, for example mild asthma, innocent heart murmurs etc.

8. Patient in pain from decayed teeth

Unregistered children with acute symptoms should be sent to the Primary Care Treatment Centre since direct referral to the Hospital Service is inappropriate. Registered patients with genuine emergencies (pain and swelling) where palliative treatment has been unsuccessful will be seen in the Child Dental Health Department as quickly as possible. Either mark the referral as urgent or call the department (see Contact details page). **If the patient is likely to require general anaesthesia complete Section G instead.**

9. Learning Difficulties & Special Needs

Do not refer to the Hospital Service. The primary route for referral of children with special needs is to the Community Dental Service. Where the CDS is unable to manage the patient, or to provide the full range of care required, a secondary referral to the hospital service may then be made.

Adult patients (i.e. 16 years and over) with learning difficulties or special needs which require referral, should be directed to the Community Dental Service at Stobhill Hospital. The Department of Child Dental Health **does not accept referrals of adult patients.**

10. Anxiety & Behaviour Management

Do not refer to the Hospital Service. Where anxiety or behaviour management is the primary reason for referral, the patient should be referred to the Community Dental Service in the first instance. It is expected that all previous efforts directed at managing anxiety will be outlined in the referral letter.

Where the CDS is unable to provide the full range of treatment required, a secondary referral may be made. Patients who are accepted for the management of their anxiety will be required to undertake a programme of prevention and acclimatisation prior to attending a Pre-Sedation Assessment Clinic.

2. RESTORATIVE DENTISTRY - Fill in Section A,C, G and I

2a. CONSERVATIVE DENTISTRY – Fill in Section A,C,C1,G I

1. Oral Hygiene

Patients referred with inadequate standard of oral hygiene will be returned to the referring practitioner for a course of hygiene phase therapy. Patients should be made aware that if their oral hygiene is inadequate the referral may not be accepted as they are unsuitable for specialist care.

2. Caries control/ Dentition Stability

The area of concern should be stabilised and maintained by the referring practitioner to avoid deterioration of the complaint until an appointment with a consultant has been arranged.

3. Priority Patients

Rehabilitation in patients with congenital defects, post-oncology problems and patients requiring treatment of a mult-disciplinary nature are considered priority. Other patients may be accepted for treatment when specialist care is required, though this will depend on the needs in the department for training and education.

4. Maxillofacial/Cleft

Specialist areas of treatment undertaken in the Department include rehabilitation in patients with congenital and acquired oral defects. These groups, considered for implant treatment, are patients who have had surgery for head-and-neck cancer, patients with congenital abnormalities such as cleft palate and hypodontia, and patients who have suffered major facial trauma.

5. Referral to Undergraduate Clinics

Suitable patients (ie those who can attend lengthy appointments and who do not have complex medical or behavioural problems) may be accepted for treatment on undergraduate clinics where treatment required is non-specialist in nature..

6. Advice Only Referrals

Patients seen for consultation only within the Department include those with aesthetic problems and patients who require a general assessment for strategic planning of restorative dental treatment.

7. Medically compromised patients

Patients with mental or physical handicap, patients who are infirm and patients who present non-anxiety related management difficulties are **NOT**, in general, accepted for treatment within the Department unless the dental situation is seen as requiring **specialist management.** These patients should be referred to Community Dental Services in the first instance.

2b. ENDODONTICS Fill in Section A, C, C2, G and I

1. De novo (*first attempt by anyone*)

Root canal treatment will only be accepted for specialist treatment in exceptional circumstances. This might include very curved canals, root resorption or teeth with open apices. If you wish non-specialist root canal treatment undertaken in our undergraduate clinic, the patient should be a good attender and be suitable for a novice in patient management.

2. Re-treatments

Not all re-treatments will be accepted for specialist treatment. A reason must be included such as removal of separated instrument, perforation repair or that previous re-treatment by yourself has been unsuccessful.

3. Periradicular Surgery

Patients requiring periradicular surgery must have an existing root canal treatment within 3mm of the apex with adequate condensation. All other cases will be returned unless the dentist is unable to re-treat or it is inappropriate to re-treat or where re-treatment has been unsuccessful.

2c. PROSTHODONTICS – Fill in Section A, C, C3, G and I

1. Oral Hygiene

Patients referred with inadequate standard of oral hygiene will be returned to the referring practitioner for a course of hygiene phase therapy. Patients should be made aware that if their oral hygiene is inadequate the referral may not be accepted.

2. Specialist Treatment

Specialist areas of treatment undertaken in the Department include rehabilitation in patients with congenital and acquired oral defects. Dental restoration using dental implants is undertaken, but there are restrictions in the categories of patients accepted for treatment. The priority groups considered for implant treatment are patients who have had surgery for head-and-neck cancer, patients with congenital abnormalities such as cleft palate and hypodontia, and patients who have suffered major facial trauma.

3. Undergraduate Treatment

Patients with complete or partial dentures may be accepted for treatment on undergraduate clinics, with the patient's consent. However, patients who are deemed to be unsuitable for treatment on undergraduate clinics, and whose treatment is not of a specialist nature, will be returned to the referring practitioner for any recommended treatment.

4. Advice Only Referrals

Patients seen for consultation within the Department include those with functional problems associated with complete or partial dentures and patients who require a general assessment for strategic planning of restorative dental treatment. Whilst patients in this category will be accepted for treatment when specialist care is required, those where prosthodontic treatment is required but is not of a specialist nature will be returned to the referring practitioner for completion of part or all of the treatment advised.

5. Medically compromised patients

Patients with special needs, patients who are infirm and patients who present management difficulties are not, in general, accepted for treatment within the Department unless the dental situation is seen as requiring specialist management.

2d. PERIODONTOLOGY – Fill in Section A, C, C4, G and I

Referrals will be prioritised according to need, so please provide as much information as possible.

1. Advice Only Referrals

This service is available for dentists wishing to undertake treatment in their own practices. The request for 'advice only' should be clearly marked on the referral form.

2. Specialist Treatment

Patients should be referred for specialist treatment of chronic inflammatory periodontal disease **only if they have a positive attitude to oral health, and have already achieved reasonably good oral hygiene, and if all accessible calculus has been removed.** Otherwise, they will be returned to the referring practitioner.

This service is available only for patients whose treatment lies <u>outwith</u> the scope of General Dental Practice. Therefore, if referrals are made with a view to treatment being undertaken within the department, the referring practitioner should make it clear why specialist treatment is being sought. As a general guide, specialist treatment may be required for inflammatory periodontal disease:-

a) associated with pockets at least 5mm deep

or

b) complicated by furcation lesions, tooth migration, excess tooth mobility, muco-gingival disorders, combined periodontal-endodontic disease etc.,

or

c) complicated by certain medical problems for which management within general practice would be inappropriate, e.g. immune deficiency etc.

Specialist treatment may also be required for epulides, cysts, root resorption, periodontal trauma, muco-gingival problems, etc.

The decision to provide treatment will be at the consultant's discretion.

Once specialist treatment is complete, patients will be discharged to their General Dental Practitioners for periodontal recall maintenance. Maintenance is an important shared responsibility of the General Dental Practitioner and patient. The resources of the department are limited and repeat courses of treatment for patients recently discharged will not normally be available.

3. ORTHODONTICS – Fill in Sections A, D, G and I

1. Oral Hygiene

Patients referred with inadequate standard of oral hygiene will be returned to the referring practitioner for a course of hygiene phase therapy. Patients should be made aware that if their oral hygiene is inadequate the referral may not be accepted.

2. Advice Only Referrals

Referred patients are seen for assessment by a Consultant Orthodontist. It is our opinion that the majority of routine orthodontic treatment can be carried out in Specialist Orthodontic Practice and the main role of Glasgow Dental Hospital is to treat patients with the more complex problems, particularly multi-disciplinary cases, which include:

- Patients requiring combined orthodontic/restorative management
- Patients requiring combined orthodontic/orthognathic surgery
- Patients with clefts of the lip and palate and other craniofacial anomalies
- Patients with ectopic teeth requiring minor oral surgery as part of their overall management
- Patients requiring combined orthodontic/specialist paedodontic management

3. Specialist Treatment

In addition, special needs patients where orthodontic treatment is not practicable within primary care will be accepted. Also, a limited number of "routine" orthodontic cases are required to support training of orthodontic specialists and may be accepted for treatment depending on requirement at any given time. Patients with a low/borderline need for treatment are not likely to be offered treatment within the Orthodontic Department.

4. Adult Referrals

Adult referrals (aged 21 or over) will be accepted for assessment but are unlikely to be accepted for treatment unless they have a particularly complex problem or a need for multi-disciplinary management. **Please make this clear to any adult patients you refer.**

5. Radiographs

Any relevant radiographs, if available, should also be sent.

6. Clinical Information

Our referral form provides space for you to give your reason for requesting an orthodontic assessment. It is particularly helpful for us to have your comments regarding the patient's motivation and likely co-operation/commitment with orthodontic treatment. For example, is this a patient whose interests, in your opinion, may not be best served by wearing fixed appliances but would be better suited to a more simple approach.

4. ORAL SURGERY – fill in Sections A, E, G and I

1. Urgent Referrals

We will accept as urgent, patients with acute oral surgical problems e.g. extraction complications, spreading infection, suspected neoplastic disease. A clinician will be available at all times to discuss these problems and make appropriate arrangements with the referring practitioner for immediate referral.

For urgent referrals telephone the Oral Surgery Treatment Area (see Contact Details page). For all routine referrals please use the referral form.

ORAL MEDICINE – Fill in Sections A, E, G and I

1. Urgent Referrals

We accept patients with acute or severe pain including severe oral mucosal ulceration and trigeminal neuralgia etc. Call the Oral Medicine Department or FAX a completed referral form if preferred (see Contact Details page).
Patients will not be seen without a pre-arranged appointment.

2. Suspected Oral Cancer

Use Rapid Access Service. (see Contact Details page)

3. Lesions Requiring Minor Oral Surgery

Please refer directly to Oral surgery. .g. mucocoele, denture induced hyperplasia, fibrous overgrowths, papillomas. If sent to Oral Medicine, referrals will be redirected to Oral Surgery.

4. Inappropriate Referrals

The following conditions should **not** be referred to Oral Medicine in the first instance.

- suspected latex hypersensitivity
- suspected local anaesthetic allergy
- possible mercury toxicity from amalgams/replacement of amalgams in patients with MS
- migraine headaches
- patients with recurrent oral ulceration (aphthae)

PLEASE SEE ADVICE NOTES for information on how to deal with these conditions.

5. Pre-Referral Management of Conditions

BEFORE considering referral, note that some conditions can initially be investigated and managed in Primary Care. If these measures are successful, the patient does not need to be referred to Oral Medicine.

a. Patients with Recurrent Oral Ulceration (Aphthae)

Consider initial symptomatic treatment with simple measures such as chlorhexidine mouth rinsing twice daily, 'Adcortyl in Orabase' applied directly to a dried ulcer or a beclometasone metered dose inhaler (e.g. Becotide-50) placed as close to the ulcer as possible and sprayed directly onto the ulcer three times daily.

Approximately 30% of patients with aphthae have a haematinic deficiency, so it is appropriate to liaise with the patient's general medical practitioner to request full blood count, ferritin, folate and vitamin B12 investigations. Correction of any deficiency may result in improvement of the oral ulceration. If these initial measures are not successful, consider referral to Oral Medicine.

b. Patients with Temperomandibular Dysfunction

Many patients respond to simple conservative measures, such as soft diet, rest, simple analgesia or an occlusal splint. If these do not result in improvement after 3 months, consider referral.

c. Suspected Allergy to Local Anaesthetic

This service is not available within Greater Glasgow and Clyde at present.

d. Effects of Mercury from Amalgam Restorations

If you suspect the patient has a contact lichenoid reaction to dental amalgams, you may wish to consider replacement of these restorations with an alternative material. Investigation of mercury sensitivity by patch testing is unnecessary before removing amalgams in contact with lichenoid reactions. There is no evidence in the peer-reviewed medical or dental literature that dental amalgams cause systemic symptoms or multiple sclerosis. You or your patient may wish to consult the following NIDR website for summaries of research findings.
http://www.nidcr.nih.gov/HealthInformation/OralHealthInformationIndex/FillingsAmalgams.htm

If a patient wishes amalgams to be replaced, this can be done in primary care and does not require referral to Oral Medicine or Restorative Dentistry.

e. Migraine Headaches

Some headaches respond to occlusal splint therapy. This can be carried out in primary care. Otherwise, patients should be managed by their GMPs.

f. Suspected Latex Allergy

Patients with suspected or proven allergy to latex pose challenges for dental care as this substance is ubiquitously present in most dental care environments. A latex-free dental environment is available for patients with **proven** latex allergy within the Maxillofacial Surgery unit at Glasgow Royal Infirmary or the Community Dental Service in Townhead Health Centre. **There is no equivalent facility in Glasgow Dental Hospital**.

- If the patient has **documented** history of anaphylaxis to latex exposure (requiring hospitalisation) the Maxillofacial Unit at Glasgow Royal Infirmary should be consulted for advice about the provision of routine dental care in a latex-free environment.

- If the patient or the dentist **suspect** that the patient may have a latex allergy (for example from a reaction periorally to latex containing dental procedure gloves or dental dam placement) the GDP or GMP should contact the Allergy & Immunology Service at the Western Infirmary of Glasgow for further advice regarding possible testing, e.g. skin prick testing.

It is **not appropriate** for the patient to be referred to either the Contact Dermatitis Unit at the Southern General Hospital or the Oral Medicine Department at Glasgow Dental Hospital as neither of these can offer investigative or treatment options for the patient and will result in an avoidable delay in arranging definitive dental provision for the patient.

5. Radiology – Fill in Sections A, F, G and I

When requesting radiographs please enclose existing radiographs from the previous two years and provide details of these. Please also provide justification for your request in section G.

6. Paediatric Assessment – Fill in Sections A, G, H and I

1. **Consent**

Please ensure that you have discussed alternative treatment options to general anaesthesia and you have explained the risks of general anaesthesia as specified in the advice sheets (Appendix I and II).

2. Signatures

Please ensure that both sections H and I have been signed.

Appendix I

Patient Information Sheet - Dental disease and its treatment in childhood.

Teeth are made up of a hard outer shell called enamel and a softer core called dentine. The blood vessels and nerves which form the living part of healthy teeth are situated in the centre of the hard outer layers.

Decay causes enamel and dentine to soften and dissolve away, resulting eventually in holes forming in the teeth. Once the decay reaches the dentine then the tooth could become painful. Pain can be caused by hot, cold or sweet foods and drinks, or by biting on the tooth. Early decay can be mended by dental treatment but more advanced decay causes the tooth to die and this makes treatment more complicated and less likely to be successful.

Unfortunately baby teeth (milk teeth) are so small that the decay can very quickly kill a tooth and can sometimes cause a dental abscess (gum boil). Once a baby tooth has died, extraction of the tooth (taking the tooth out) can be the best way and sometimes the only way to treat a diseased tooth.

Our permanent (adult) teeth are larger and are more easily treated with a more predictable long term result i.e treatment is more likely to be successful.

Is it possible to treat baby/milk teeth where the nerves are affected by decay or is extraction inevitable?

It is sometimes possible to treat baby teeth when the nerves are already affected by decay. This can be a time-consuming exercise that means that the child has to sit for relatively long periods of time and possibly on several occasions before treatment is completed. There can never be any guarantee that the treatments will be successful. It is possible that further treatments including dental extraction may be necessary.

For children with more than one seriously decayed tooth it may be kinder to arrange to have all the diseased teeth extracted. This should allow the parents to concentrate on making sure that they clean their child's remaining teeth with a fluoride toothpaste and alter their child's diet to reduce the frequency of intake of foods and drinks which contain sugar. In this way the risk of developing further decay will be reduced.

How many teeth need to be extracted?

All too frequently, the younger a child is when toothache first occurs, the greater the number of teeth affected by decay and the worse the condition of individual decayed teeth.

The extent of decay in baby teeth is sometimes difficult to see and the dentist may request an X- ray. The X-ray may show that more teeth have decay into dentine and near the pulp than was first thought. These teeth may not be causing pain at the moment but they could do so at any stage in the near future and cause problems. We may decide to take these potentially troublesome teeth out now along with the more obviously decayed teeth because:

1. We want to reduce the number of General Anaesthetics that the child has in their lifetime.
2. We want to reduce to a minimum the likelihood of further dental pain in the near future.

What options are available to make tooth extraction as painless as possible for child patients?

1 Local anaesthetic

This involves an injection(s) that causes the tooth and surrounding gum to be numbed**.** The child remains conscious and will be aware of his/her surroundings. Local anaesthetic may not be appropriate for very young children or when teeth in all areas of the mouth are to extracted. Some children just do not co-operate sufficiently to allow the dentist to treat the child satisfactorily and safely.

2. Sedation

For some children, a combination of sedation and local anaesthetic is sufficient to allow treatment to be given. The sedation reduces the child's fear and worries about dental treatment to such an extent that they are able to accept a Local Anaesthetic, fillings and dental extractions.

The child breathes a mixture of oxygen and sedative gas through a small nosepiece. This requires a degree of understanding and co-operation from the child. It may not be suitable for young children or for those children who require

multiple extractions or are in acute pain. It may also be necessary to carry out treatment over a number of visits in order to allow the child to gain confidence in this method.

At all times, the child is conscious and is able to respond to instructions from the dentist. At the end of the treatment the child may not have a clear recollection of the treatment which he/she has had completed and is usually happy to return for further treatment.

3. General Anaesthetic

When a general anaesthetic is given, the patient is unconscious and will have no recollection of the dental procedures. This form of anaesthesia is most frequently necessary when patients are too young to understand instructions and are unable to co-operate with the dentist to allow the treatment to be carried out safely under options 1 or 2 above.

Occasionally local anaesthetic, or a combination of local anaesthetic and sedation, is not an option due to the child's medical and or/dental condition. General anaesthetic may, therefore, be the only treatment option than is available.

Fuller details about General Anaesthetic are available on a separate sheet entitled ***Risk and General Anaesthesia for Dental Extractions*** *in Children. Please read the leaflet with care.*

A General Anaesthetic will only be given for dental extractions when all other alternative methods are either inappropriate or have been tried without success. Children who require to have teeth extracted for orthodontic reasons will not be offered General Anaesthetic in Greater Glasgow and Clyde NHS premises unless specific exceptional circumstances prevail

Appendix II

Risk and General Anaesthesia for Dental Extractions in Children

All general anaesthetics are associated with some risk and modern dentistry is based on the principle that all potentially painful treatment should be performed under local anaesthesia if possible.

If a general anaesthetic is the best way to carry out your child's treatment, there are some risks you should be aware of.

Serious complications (death or severe brain damage) which you may have read about in the press are extremely rare. The risk of death in the dental chair under anaesthetic has been quoted as 1/150,000 but we believe the risk at the Dental Hospital is much less than this because of modern anaesthetics and equipment and our training and staffing levels.

Minor complications can occur. These include pain, bleeding and sickness. The majority of children will have local anaesthetic injected into their gums during the procedure and we find this is a very effective pain-killer. Your child may experience some facial numbness (pins and needles) from the local anaesthetic. When this wears off, simple pain-killers (for example Calpol) are usually all that is required. Your child's mouth will be carefully checked after the extractions and any bleeding will be dealt with before they are allowed to leave. With modern anaesthetics, sickness is unlikely to be much of a problem.

If you would like to discuss any of these issues in more detail, please speak to anaesthetist who is dealing with your child on the day of the extractions.

Glasgow Dental Hospital & School

Contact Telephone Numbers

If you would like any help or advice on a clinical matter relating to one of your patients or you would like advice on the referral of a patient please call on one of the following telephone numbers.

All numbers start with 0141 211

Main switchboard	**9600**
Fax number for referrals	**9682**
Fax number for rapid access (suspected oral cancer)	**9837**
Conservation	**9781**
Periodontology	**9772**
Prosthodontics	**9633**
Paediatric Dentistry	**9671**
Orthodontics	**9793**
Oral Medicine	**9643**
Oral Surgery	**9660**
Sedation	**9812**
Paediatric Assessment	**9702**