

# Glasgow Dental Hospital Referral Form

Date of Referral: \_\_\_/\_\_\_/\_\_\_

## Section A - Patient Details:

Surname: _____		Male/Female
First Names: _____	Date of Birth ___/___/___	
Address: _____		
Town: _____	Post Code: _____	
Phone: (Day) _____	Eve: _____	Mobile: _____

## - Referring Dentist/Doctor Details:

Name: Address:    Phone:	Hospital Use Only:
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Is patient registered with practice  CHI No. (if known)

Routine:  Urgent:  \* You must justify urgent request overleaf Rapid Access

Has patient attended GDH before? Yes  No  If so state Hosp No

## Referral to:

(please refer to individual guidance notes when completing this section)

## Section B - Paediatric Dentistry (not GA Assessment) (please read guidance notes 1)

Problem:	Is the patient symptomatic <input type="checkbox"/>	Radiographs enclosed <input type="checkbox"/>
Dento-alveolar trauma <input type="checkbox"/>	Molar/incisor hypoplasia/mineralisation <input type="checkbox"/>	
Tooth discoloration <input type="checkbox"/>	Developmental defects <input type="checkbox"/>	
Non-carious tooth surface loss <input type="checkbox"/>	Soft tissue disorders/lesions <input type="checkbox"/>	
Medically compromised <input type="checkbox"/>	High caries rate <i>or</i> pain from decayed teeth* <input type="checkbox"/>	
Learning difficulties and special needs* <input type="checkbox"/>	Anxiety and behaviour management* <input type="checkbox"/>	
Other ----- <input type="checkbox"/>	* Should be referred to Community Dental Service in the first instance	

## Section C - Restorative:

Radiographs enclosed

Standing teeth:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

CPITN:


## Section C1 - Conservation:

(please read guidance notes 2a)

Problem:

For advice only  For Specialist treatment  Undergraduate treatment

(at Consultant's discretion)

Toothwear  Fixed Prosthodontics  Pain Diagnosis

Purely Cosmetic (advice only)  Maxillofacial/Cleft  Anxiety/Hypnosis

Other (specify)-----  Caries present  Is the caries controlled

## Section C2 - Endodontics:

(please read guidance notes 2b)

Problem:

De novo  Re-treatment

Periradicular surgery  Trauma\*

Are adjacent pockets <4mm  Is tooth caries free and restorable

Duration of condition  Previous episode (provide details in Section G)

\*Patients under 16 years of age should be referred to Paediatric Dentistry

## Section C3 - Prosthodontics:

(please read guidance notes 2c)

Problem:

For advice only:  For treatment: Specialist  Undergraduate

(at Consultant's discretion)

Edentulous  Partially dentate

Are dentures worn by the patient: Yes  No

Were the dentures made by you: Yes  No

Periodontal Status Disease present - (give details in Section F)  Is the caries controlled

## Section C4 - Periodontology:

(please read guidance notes 2d)

Problem:

For advice only

or

For specialist treatment   
(at Consultant's discretion)

Please refer to guidance notes for an outline of those conditions for which specialist treatment is available. Patients with poor oral hygiene or obvious calculus deposits will not be accepted for treatment.

## Section D - Orthodontics:

(please read guidance notes 3)

Problem:

For Advice only

or

For specialist treatment   
(at Consultant's discretion)

## Section E - Oral Surgery/Oral Medicine: (please read guidance notes 4)

Problem:

Oral Surgery

Oral Medicine

## Section F – Radiology: (please read guidance notes 5)

Problem:

Previous relevant radiographs included

When were they taken?

## Section G - Referral Details:

Reason for referral: (Justify urgent requests)

History of complaint and duration of condition:

Previous investigation and treatment:

Relevant medical and drug history:

Examination findings:

Provisional diagnosis:

## Section H – Paediatric Assessment:

### Section H1 - Provisional Treatment Plan: (please read guidance notes 6)

Extraction of: \_\_\_\_\_

#### Justification for Referral:

- I have discussed alternative means of care as specified in the advice sheet (Appendix I)
- I have explained to the parent /guardian/patient (\*delete as appropriate) the proposed procedure and the risks of general anaesthesia as specified in the advice sheet (Appendix II)
- I have explained that the treatment plan may be changed at the assessment appointment and I have explained that the parent/guardian/patient will be advised of any such changes.

**(NB sign end of referral sheet)**

## Section H2 – Parent/Guardian/Patient to complete

I confirm that Dr/Mr/Mrs/Miss/Ms \_\_\_\_\_ has discussed with me the alternative means of care as specified in advice sheet (Appendix I).

I am satisfied with the explanation given to me for the need for referral. I agree to the referral for assessment for sedation/general anaesthesia following the explanation of the proposed procedure and the risks of general anaesthesia as specified in the advice sheet (Appendix II).

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
parent/guardian/patient (delete as appropriate)

**Section I** – Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Referring Practitioner

### For Hospital Use Only:

Accept  Priority: Urgent  Soon  Routine

Reject  Because of insufficient information  Inappropriate referral

Advice only  Date vetted:  Vetted by: \_\_\_\_\_ Signed

**CHI No**

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**Internal Audit**

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