**Referral Form for Dental Assessment**

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| Child/ Young Person Name and DOB |  |
| Address and POSTCODE | |
| Contact Person (Parent or carer) |  |
| Contact Telephone Number |  |
| Name of person legally able to consent to dental treatment for the child. **(It is essential this person is present at the dental appointment)** |  |
| Child protection medical (if applicable)  Completed on: |  |
| Initial Health Assessment (IHA) (if applicable)  Completed on: |  |
| Review Health Assessment (If applicable)  Completed on: |  |
| Named Social Worker (if applicable) | Email and phone no. |
| Name of GP | Email and phone no. |

Child’s vulnerabilities (Please tick as appropriate)

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|  | Child has undergone a child protection medical examination and requires assessment as part of holistic health review to be reported to Paediatrician and Social Worker (if identified above). |

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|  | Child is in the Care of the Local Authority: an initial assessment is required to have a dental health check as part of a full health review within 20 days of coming into care or annual review as part of their follow-up Review Health Assessment. Dental report to be sent to referrer and Social Worker |

Please note any additional needs of the child that the Dentist will need to be aware of to support their assessment.

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Reason for referral: What are your concerns regarding the child’s dental health from your observations /discussions with parent or carer or child

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Past dental history: details of dental attendance, previous treatment undertaken, any special requirements e.g. anxiety/ previous refusal to attend

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Relevant medical history e.g. details of prescribed medication / clinical conditions

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What attempts have been made to access a local dental practice

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| Date of referral |  | Signature | |
| Name of Practitioner referring Child |  |
| Address of Practitioner |  | Designation (Role) of Practitioner referring |  |
| Contact Telephone No. of referrer |  | Email of referrer  (nhs.net) |  |

**This referral has been copied to the social worker**

**Dental Practice Report to Referring Practitioner**

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| Name of Child and DOB  Date referral received: |  |

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| Name of Practitioner referring Child: |  |
| Practitioner’s Role: |  |

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| Dentist name and Address of Dental Practice |
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**I am writing to inform you that the above child**

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|  | Was seen as a new dental patient on (date of appt) |  |

Advice given / treatment planned/provided

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|  | Was seen for treatment on (date/s of appt) |  |

Advice given / treatment provided.

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|  | Child was Not Brought to appointment on; *(if applicable)* |  |

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|  | As this is the 1st missed appointment a further appointment will be  offered, please could you provide support to the child to attend on: |  |

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|  | No further appointment will be offered as this is the 2nd missed appointment and the child will be discharged from our service (date of 2nd appointment offered) |  |

Details of impact of non-attendance on the child

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|  | Dental report to referring Paediatrician (IHAs and child protection medical) |  |

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|  | Dental Report provided to referring Nurse completing Review Health Assessment |  |

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|  | Dental report forwarded to Social Worker |  |

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