

Community Dental Service – Referral Form

For this referral to be considered for triage by the CDS team it must be fully completed by the referring practitioner; incomplete forms will be returned to the referrer.

(all areas marked with an * are mandatory)



Cardiff & Vale
Community Dental Service
Gwasanaethau Deintyddol Cymunedol
Caerdydd a'r Fro

Service Required (circle): Special Care Dentistry / Domiciliary / Sedation / Intermediate Bariatric (up to 30 Stone)

Patient Full Name: *

DOB: *

NHS Number:*

Biological Sex: Male

Female

Ethnicity:*

Address, including postcode*

Email Address *

Tel No: *

Mobile: *

As a service we would like to become paperless, therefore, would you consent to receiving correspondence via email and /or text messaging? (Please Circle) *

Yes

No

First Language Spoken: *

Is an Interpreter required? (Please circle) *

Yes

No

Name of next of kin / Carer / Person or body with parental responsibility*

Relationship to patient: *

Contact number: *

Name of Social Worker*

Contact number: *

Is there an LPA appointed (adults) (Please circle) * YES or NO

Name of LPA:

Contact number

General Medical Practitioner Name, address and tel. number *

Medical Conditions *

Medications *

Relevant Social History*

Patients

Weight kg

Height cm

Reason for referral: *

Supporting information: Please outline how patient's condition affects their ability to undergo dental care.

For persons with learning disability, ASD, ADHD or other neurodiversity Please state whether mild/moderate/severe

Referral status: (circle) *

Urgent (pain and /or swelling)

Non-urgent

Do you have your own natural teeth (circle) *

Yes

No

How is the patient's mobility? *	Ability to communicate *	Have they capacity to consent? *
Walks unaided	Full	Yes
Needs assistance	Limited	No
Needs hoist transfer	Other:	Don't Know

How do you travel to your appointments? (Please circle) * **Ambulance transport** **Car** **Other**

Criteria for referral, please tick box(es) applicable for patients with:

Learning disability	01	Patients whose cognitive abilities are such that they are unable to manage their own oral care, particularly those who need carers to support their daily activities, including dental visits
Mental health problems	02	Patients with diagnosed mental illness who need additional skills and facilities to manage their oral care
Physical disabilities and access issues	03	Patients whose mobility / physical disability requires specialist facilities and / or skills to manage their oral care. i.e. hoists, recliners to facilitate transfer or access to patients' mouths
Complex medical needs	04	Complex medical conditions which affect their oral health and / or dental treatment, and require liaison with medical consultants
Anxiety and phobia	05	Patients for whom there is evidence that they have dental phobia and / or anxiety which affects their ability to receive dental treatment in GDS i.e. require sedation
Cognitive impairments	06	Patients with cognitive impairments i.e. Brain Injury, Dementia
Intermediate Bariatric patients	07	Patients who exceed the weight limit of dental chairs (normally between 21 stone and up to 30 stone) patients who weigh in excess of 30 stone will require a referral to secondary care (University Dental Hospital)
Vulnerable groups (please circle)	08	Homeless people / substance misusers / Asylum Seekers
Frail older people	09	Older people who because of their frailty and complex medical / social needs are unable to access care in the GDS
Other	10	Please state:

Referrers Name: *	Address: *
Email Address: *	Post Code: *
	Tel: *

Please return this form: By Email: cavcommunity.dentalservice@wales.nhs.uk

By post to: Community Dental Service, Dental Department Riverside Health Centre, Wellington St, Canton, Cardiff, CF11 9SH