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

Special Care Dentistry - Health Inclusion

Patient Full Name: *			
DOB: * **Ethnicity:***	**NHS Number:**		
Biological Sex: Male ☐ **Female** ☐			
Gender Identity:			
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: ***		
General Medical Practitioner Name, address and tel. number *			
Medical Conditions *	**Medications ***		
Relevant Social History*	**Smoker?** ☐ **How many/day?** **Alcohol?** ☐ **Units/day?**		
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:

Homeless	01	☐
Refugee	02	☐
Sex Worker	03	☐
Asylum Seeker	04	☐
Prison Leaver	05	☐
Substance Misuse History	06	☐
If yes to 06, provide details:		
Other	07	Please state:

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

Please return this form:
By post to: Community Dental Service, Butetown Health Centre, Loudoun Square, Bute Street, Cardiff, CF10 5UZ or by email: HealthInclusion.team.CAV@wales.nhs.uk

For Completion by Community Dental Service					
Date referral processed			**Triaged by**		
Referral Outcome (Please Circle)	Accepted		Rejected	**Waiting List (circle):** HI NP HI Therapist NP Other:	
Waiting List priority (Please Circle)	Low	Medium	High		