Referral Form for (UHB) PCDS

Name _____

Address _____

_____

Postcode _____

Telephone number _____ Email

Date of Birth _____

Gender _____ NHS No.

Ethnic group

Reason for referral _____

_____

.....

Urgent □ Please state reason ……..

Non-urgent □

Surgery Visit □ Domiciliary visit □

Please note that only those who are house bound who are totally unable to leave their homes are seen on a domiciliary basis

Special care needs _____

.....

Social history _____

Please include availability and carer contact details .....

Medical history please complete attached form

Medication list _____

_____

.....

NHS dental charges will be applied unless proof of exemption is provided.

NB If you are in receipt of the following you are not exempt:

- Aged over 65
- Disability living allowance
- Incapacity benefit including income based.

Exempt from charges No ☐ Yes ☐ benefit ……..

Please attach copy of qualifying exemption certificate

Sensory impairment

Hearing ☐ Vision ☐ Communication ☐

Mobility

Can manage stairs ☐ Can walk with frame ☐ Can weight bear ☐

Wheelchair ☐ Bed-bound ☐ Hoisting required ☐

Referring Practitioner:
Name _____
Address _____
Postcode _____
Telephone number _____ Email _____
Preferred site _____

Refer to PCDS Clinic – contact details
http://www.uhbristol.nhs.uk/primary-care-dental-services

MEDICAL HISTORY

Name & Address of GP: ----------

		NO	YES	DETAILS
	Are you currently under the care of a doctor or having hospital treatment for any condition?			
	Are you/could you be pregnant? Due date?			
	Do you have/have you ever had any of the following:			
CVS	HEART DISEASE (e.g. angina, heart attack, heart murmurs, valve problems, heart surgery)?			
	Rheumatic Fever, Endocarditis?			
	High blood pressure, Stroke?			
	Bleeding Disorder, Taking anticoagulants, anaemia?			
RS	ASTHMA, Bronchitis, TB other chest disease?			
	Smoker (past/present) – how many per day?			
GI	HEPATITUS, jaundice, other liver disease?			
GU	KIDNEY, urinary tract or sexually transmitted disease?			
CNS	EPILESPSY, convulsions, neurological disease?			
	Learning difficulties?			
	Mental Illness/Psychiatric Problems?			
	Alcohol or Drug addiction (past/present)?			
LM	DIABETES, thyroid, other hormone disorders?			
	Bone or joint disease?			
	Skin Disease e.g. eczema, dermatitis?			
	ALLERGIES (e.g. penicillin, aspirin, paracetamol, latex, elastoplast)?			
	Any other diseases or conditions?			
	Previous operations?			
	Previous serious illnesses or admissions to hospital?			

Do you take any medication (prescription/over the counter)? Please list below:

Additional information please continue overleaf.

Signed by Patient/Parent/Carer: ----------
Signed by Clinician ---------- Date ----------