

## Bristol Dental School Endodontic Referral Form

Please complete and post to: Patient Administration Team, Bristol Dental School, 1 Trinity Quay, Avon Street, Bristol, BS2 0PT  
 Email [student-treatments@bristol.ac.uk](mailto:student-treatments@bristol.ac.uk) or call if you have any questions or call 0117 374 6647.

Please be aware of our patient acceptance criteria, our sole purpose is clinical education and training, and therefore will reject any referrals that do not meet the needs of our students. Our acceptance criteria can be found [here](#).

The Dental School will accept patients for endodontic treatment on a shared care basis. Referral will require that all other patient's dental health needs will still be the responsibility of the referring clinician. All patient's restorative treatment will have had to be completed before referral. The school will accept patients whose endodontic treatment needs falls under the category level 1 (care that is expected by a general dental practitioner in primary care). On completion of treatment the patient (usually including endodontic treatment plus Crown) will be referred back to your care with a report of treatment provided for ongoing maintenance under your care. The school will endeavour to also provide the appropriate coronal restoration before referral back to your care.

### ACCEPTANCE CRITERIA

Cases will be considered for acceptance based on the following criteria;

- Can accept treatment under routine local anaesthetic
- If the patient has a stable oral environment
- The tooth/teeth which require treatment are of strategic importance and can be made predictably functional with a favourable prognostic success rate.
- Root canals with a curvature <30 degrees to root axis and considered negotiable, from radiographic evidence, through their entire length.
- No root canal obstruction or damaged access, e.g. perforation.
- Routine dismantling of plastic restorations, crowns and bridges to assess restorability.
- Pulp extirpation as an emergency treatment.
- Incision and drainage as an emergency treatment.
- Straightforward retreatment.
- Patients who cannot meet NHS charges

Patients will not be offered treatment if:

1. They have an unstable oral environment i.e. poor oral health, active caries and/or active periodontal disease
2. They are "keen to save" the tooth/teeth but the prognosis is considered poor
3. The tooth is a second or third molar unless it is of strategic value to the overall treatment plan
4. They require sedation or GA for routine dental treatment.

Please refer to our full acceptance [criteria](#).

### TRIAGE INFORMATION (FOR BRISTOL DENTAL SCHOOL USE ONLY)

Is this referral for: *(please tick)*

**A) Suitable for U/G Assessment**       **B) Not Suitable**

### PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT

Has the patient understood and consented to the referral and is happy (if accepted) for treatment to be delivered by oral health care professionals undergoing training?

YES

### RADIOGRAPH

A diagnostically acceptable **RADIOGRAPH must be included** with this referral, or it **will be rejected**.

Date taken

**Please do not send wet processed films**

**CLINICAL INFORMATION**

Primary RCT       Suspected Perio-Endo lesion      (please tick)

**IS THE TOOTH RESTORABLE?**       Yes       No

**CLINICAL REASON FOR REFERRAL.** Please detail reason for referral and what you want us to do for your patient.

**RELEVANT PREVIOUS TREATMENT HISTORY.** Please detail.

**WHY IS THE TOOTH IMPORTANT?** (please tick)

Appearance       Strategic (e.g. abutment tooth)       Occlusal stability       Function

**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

**BPE Score:**


**ADDITIONAL INFORMATION**

**SMOKER/VAPOUR/EX SMOKER**      YES  Number of years and number per day.      NO   
(delete as required)

**ALLERGIES** - Please state allergy and description of reaction, if known.      YES  please detail.      NONE

**Medical Conditions:** Tick box 1 if none. Complete if other.

1. No relevant medical history confirmed

**Current Medication:**

Bisphosphonates/Denosumab state no of years.....

**Tick ALL relevant boxes**

- Warfarin\* stable and INR below 3.5
- NOACs e.g. rivaroxaban
- Aspirin/Clopidogrel
- Bleeding disorders
- Bisphosphonates (oral)
- Bisphosphonates (IV)
- DMARDS (Drugs for rheumatoid conditions)
- Oral Steroids
- Uncontrolled Diabetes
- Cardiac Valve replacement
- Immunosuppressant's
- Chemotherapy

**MEDICATION** - Please state type and dosage details.      YES  please detail.  
NONE

**OTHER INFORMATION** (E.g. Living arrangements, Legal guardian)

FULL PATIENT DETAILS	REFERRER DETAILS
Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> NHS Number: Surname: First name: Date of Birth: Address: Town/City: Postcode: Telephone Number: Mobile Number: E-mail Address:	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="checkbox"/> Surname: First name: Job Title: GDC Number: Practice Name: Practice Address: Town/City: Postcode: Telephone Number: E-mail Address:
PATIENT GMP DETAILS	COMMUNICATION & SPECIAL REQUIREMENTS
Practice Name: Practice Address: Town/City: Postcode: Telephone Number: E-mail Address:	Does the patient communicate in a language or mode other than English? YES <input type="checkbox"/> please detail. NO <input type="checkbox"/> Is an interpreter required? YES <input type="checkbox"/> please detail. NO <input type="checkbox"/> Does the patient have any special requirements? YES <input checked="" type="checkbox"/> please detail. NO <input type="checkbox"/>
CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER	
Has the patient understood and consented to the referral and is happy (if accepted) for treatment to be delivered by oral health care professionals undergoing training?  <div style="text-align: center;">             YES <input type="checkbox"/>                      NO <input type="checkbox"/> </div>	
<b>Print Full Name:</b> .....  <b>Date:</b> .....  <b>Signature:</b> .....	