**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.**

|  |  |
| --- | --- |
| **ACCEPTANCE CRITERIA** | |
| General patient criteria as shown on our website:  [bristol-dental-school-patient-acceptance-criteria.pdf](https://www.bristol.ac.uk/media-library/sites/dental/documents/bristol-dental-school-patient-acceptance-criteria.pdf)  Since academic teaching is the primary aim, we are looking for people who meet the following criteria:   * Can commit to multiple appointments some of which may take up to 3 hours * Can be flexible to attend on different days of the week, and able to attend the School * Have dental needs that can be managed in a primary care setting * Are reasonably healthy (See ASA reference table below):   + ASA 1 – Clinically healthy   + ASA 2 – Mild systemic disease without significant functional limitation   + Some ASA 3 – Severe systemic disease with significant functional limitation – clinical   + discretion advised * Ambulatory and can transfer to a dental chair and are under the recommended weight limit for the dental chair. * Non-ambulatory, but can accept treatment safely in a wheelchair in a dental cubicle or be transferred to a dental chair using accepted transfer aids. * Are willing to have various aspects of their dental needs cared for by different students concurrently, under the supervision of a qualified dental professional   **Oral Surgery**  Pain and anxiety management:   * Patient must be self-assessed as not anxious using a Modified Dental Anxiety Scale (MDAS) questionnaire. Those assessed as very or extremely anxious are excluded. * Patient will accept and be suitable for local anaesthesia alone for treatment (treatment under sedation or general anaesthetic not available).   Treatment complexity:  Level 1 (routine) procedures (Guide for Commissioning Oral Surgery and Oral Medicine, 2015) including:   * Routine extraction of erupted teeth (not impacted third molars or unerupted teeth) * Extraction as appropriate of tooth roots (whether fractured during extraction or retained root fragments), including tooth sectioning. | |
| **TRIAGE INFORMATION (FOR BRISTOL DENTAL SCHOOL USE ONLY)** | |
| Is this referral for: *(please tick)*  **A)**  **Suitable for undergraduate student 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 undergraduate students in training, under the supervision of a qualified dental professional  YES | |
| **REASON FOR REFERRAL** | |
| REASON FOR REFERRAL/CLINICAL DETAILS. Please detail reason for referral and what you want us to do for your patient.  TREATMENT REQUESTED  Extraction | |
| **TREATMENT HISTORY.** Please detail. | |
| **RADIOGRAPH** | |
| Please provide as high quality printed images or as pdf if emailing to the above email address.  Please do not send wet processed films | |
| **MEDICAL HISTORY/SOCIAL DETAILS** | |
| |  |  | | --- | --- | | **Medical Conditions: Tick box 1 if none. Complete if other.**    **1. No relevant medical history confirmed**    **Current Medication:** | **Tick ALL relevant boxes**  **Warfarin\* (stable INR below 3.5)**  **DOACs e.g. Rivaroxaban**  **Aspirin/Clopidogrel/ other antiplatelet**  **Bleeding disorders**  **Bisphosphonates (oral/IV) (number of years)**  **Other bone modifying agents**  **DMARDS (Drugs for rheumatoid conditions)**  **Oral Steroids**  **Uncontrolled Diabetes**  **Cardiac Valve replacement**  **Immunosuppressant’s**  **Chemotherapy** | | |
| **MEDICATION LIST -** Please state type and dosage details. Or attached prescription.  **YES**  please detail. **NONE** | |
| **ALCOHOL COMSUMPTION YES**  Number of units a week. **NONE** | |
| **SMOKER/VAPOUR/EX SMOKER YES**  Number of years and number per day. **NO**  *(delete as required)*  Where appropriate, patients who smoke should be encouraged to cease the habit on the basis that treatment outcome, e.g. Perio, is often poor | |
| **ALLERGIES -** Please state allergy and description of reaction, if known. **YES**  please detail. **NONE** | |
| **OTHER INFORMATION** (E.g. Living arrangements, Legal guardian) | |
| **FULL PATIENT DETAILS** | **GDP (REFERRER) DETAILS** |
| Mr  Mrs  Miss  Ms  Dr  Other  Male  Female  NHS Number:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Mobile Number:  E-mail Address: | Mr  Mrs  Miss  Ms  Dr  Other  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  please detail. NO  Is an interpreter required? YES  please detail. NO  Does the patient have any special requirements? YES  please detail. NO |
| **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?  YES  NO | |
| **Print Full Name:…………………………………………………………………………………………………**  **Date:………………………….........................................................................................**  **Signature: …………………………………………………………………………………………………….……** | |