

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 periodontal 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 periodontal 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 will be referred back to your care with a report of treatment provided for ongoing maintenance under your care. For more severe periodontal conditions this may advise referral for specialist assessment.

### ACCEPTANCE CRITERIA

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

Where appropriate, patients who smoke should be encouraged to cease the habit on the basis that treatment outcome is often poor.

#### The following patients may also be referred:

- Patients with recurrent acute necrotising ulcerative gingivitis/periodontitis, non-plaque related gingival/periodontal conditions, localised gingival recession or medication associated gingival enlargement may be referred.
- Patients considered to require mucogingival surgery (for recession) may be referred.
- Patients with endo-perio conditions

#### Non-Acceptance Guidelines:

- The following categories of patient should NOT be referred:
- Irregular attenders in general dental services.
- Those unwilling or unable to meet NHS or private charges for treatment as the main basis for referral.
- Those who have continual poor oral hygiene.
- Those with active periodontal disease who have not received the expected initial periodontal treatment outlined above.
- Those unable to be treated under local anaesthetic.

#### Discharge from the Care Network

- All periodontal patients will be discharged back to their own Dental Practitioner for supportive periodontal therapy.
- Re-referral of patients should not be made if disease recurrence results from a failure to comply with OHI or a lapse in oral hygiene without this being rectified by the General Practitioner or Practice Hygienist.
- Smokers whose treatment response has been poor may be re-referred if they make substantial effort to reduce the habit.

### 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

Is a diagnostically acceptable **RADIOGRAPH** included with this referral?

YES

Date taken:

NO  Reason if not.....

**CLINICAL INFORMATION**

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

**RELEVANT TREATMENT HISTORY.** Please detail.

**PLEASE TICK TO CONFIRM CARIES HAS BEEN MANAGED FOR STABILISATION PRIOR TO REFERRAL?**

Yes  No  Reason if not:

**STAGE (1-4) OF PERIODONTITIS**

**Grade (A-C) OF PERIODONTITIS**

**DIABETES?** Yes  No

**IF YES, CONTROL LEVEL?**

**FAMILY HISTORY OF PERIODONTITIS?** Yes  No

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

**BPE Score:**


**MEDICAL HISTORY/SOCIAL DETAILS**

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

1. No relevant medical history confirmed

**Current Medication:**

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

**Tick ALL relevant boxes**

- Warfarin\* stable 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

**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 <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 type="checkbox"/> please detail. NO <input type="checkbox"/>
CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER	
<p><i>I confirm that this patient referral meets the current referral guidelines as issued by the South West MCN.</i></p> <p><i>I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment.</i></p> <p>Please tick to confirm. <input type="checkbox"/></p>	
<p><b>Print Full Name:</b>.....</p> <p><b>Date:</b>.....</p> <p><b>Signature:</b> .....</p>	