Bristol Dental School Prosthetics (Denture) 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 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 prosthetic 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 and periodontal treatment will have had to be completed before referral. The school will accept patients whose prosthetic 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.

ACCEPTANCE CRITERIA

Summary of acceptance criteria

Diagnosis and management of patients with uncomplicated prosthodontic treatment needs including but not limited to:

- Straightforward patient factors and medical history represent commonly encountered conditions and a wide range of less common conditions that have no significant implications for routine dentistry.
- Can accept treatment under routine local anaesthetic.
- Technical treatment delivery at routine level 1 of complexity - All routine plastic, fixed and partial removable restorations where conforming to existing occlusion. Fixed restorations where aesthetic, functional and occlusal stability and control can be maintained All removable restorations where the hard and soft tissue anatomy is healthy and reasonably well formed

Our full acceptance criteria can be found here.

TRIAGE INFORMATION (FOR BRISTOL DENTAL SCHOOL USE ONLY)

Is this referral for: *(please tick)*

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

REFERRAL INFORMATION

☐Maxillary Denture ☐Mandibular Denture ☐Both *(please tick)*

PLEASE TICK TO CONFIRM TREATMENT OF PRIMARY DENTAL DISEASE HAS BEEN COMPLETED? ☐Yes ☐No

Reason if No……

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/s** included with this referral?	☐YES ☐NO Reason if not…….

CLINICAL INFORMATION

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.

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

Edentulous? ☐YES ☐NO

BPE Score:

ADDITIONAL INFORMATION

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

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	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: ……