**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.**

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| **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.
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| **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 professionalYES [ ]  |
| **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** |
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| **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** |

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| **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 [x]  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: …………………………………………………………………………………………………….……**  |