Bristol Dental School Paediatric Dentistry 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.

ACCEPTANCE CRITERIA & CONSENT

1. Patient

- Children aged 3-16 years
- Registered with a primary care dentist
- Treatment deemed suitable for undergraduate training and would fit within the primary care setting (Level 1 Care)
- Reasonable compliance and cooperation for dental treatment
- ASA 1 (clinically healthy) and ASA 2 (mild systemic disease without significant functional limitation)

2. Treatment provided

- Preventive care and Acclimatisation
- Restorations of primary and permanent teeth if deemed restorable within a primary care setting.
- Dental extractions under local anaesthesia +/- inhalation sedation
- Aesthetic treatments - improvement in the appearance of vital, discoloured anterior permanent teeth using micro-abrasion and / or localised composite veneers

3. Diagnoses

- Dental caries - decayed primary and permanent teeth in a compliant child
- Hypomineralised primary molars
- Localised anterior dental defects.
- Trauma - injured teeth- minor trauma which will include enamel or enamel dentine fracture in a compliant
- child

Please refer to our full acceptance criteria.

I confirm I have read the "Suitability for Student Treatment" document and parent/guardian has consented to this referral (please tick)

Yes ☐

TRIAGE INFORMATION (Dental School Use Only)

Urgent (within 2 weeks) ☐ Routine ☐
Suitable for all year groups ☐ If not, specify which year group …….

Date Triaged ……/……./…… Triaged By: Clinic:

REFERRAL INFORMATION

CLINICAL REASON FOR REFERRAL:

PROVISIONAL DIAGNOSES:

RELEVANT PREVIOUS TREATMENT: (Please detail including prevention)

RADIOGRAPHS	
Is a diagnostically acceptable radiograph included with this referral?	Yes ☐ No ☐ Reason if No …….

ADDITIONAL INFORMATION

MEDICAL HISTORY: (Include all significant hospitalisations, operations, ongoing treatment and medication) Yes (please detail below) ☐ None ☐

SMOKER/VAPER:
Yes ☐ Number per day…… No ☐

MEDICATION: (Include name and dosage)
Yes (please detail below) ☐ None ☐

ALLERGIES:
Yes (please detail below) ☐ None ☐

OTHER INFORMATION: (Living arrangements, Legal Guardian, Social Workers)
Yes (please detail) ☐ None ☐

Does the patient communicate in a language or mode other than English?
Yes (please detail) ☐ None ☐

Is an interpreter required?
Yes (please detail) ☐ None ☐

Does the patient have special requirements?
Yes (please detail) ☐ None ☐

PATIENT DETAILS	PARENT/GUARDIAN DETAILS:
Male ☐ Female ☐ NHS Number: Surname: First name: Date of Birth: Address: Town/City: Postcode:	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐ Surname: First name: Relationship to child: Address: Town/City: Postcode: Telephone Number:
REFERRER DETAILS	**GP DETAILS (if not the referrer)**
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐ Surname: First name: Job Title: GDC/GMC Number: Practice Name: Practice Address: Postcode: Telephone Number:	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐ Surname: First name: Job Title: GMC Number: Practice Name: Practice Address: Postcode: Telephone Number:

CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER

- I confirm that the patient referral meets the referral guidelines for the University of Bristol Dental School.
- I understand that incomplete and/or inappropriate referrals will be returned for revision, and this will delay the patient treatment.
- The patient and parent/guardian has 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: ……

- 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. Please refer to our full acceptance here
- The Dental School will accept patients for paediatric 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.
- The school will accept patients whose paediatric 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 discharged back to your care with a report of treatment provided for ongoing maintenance under your care.