Cork University Dental School & Hospital: Referral Form

Please complete both sides and every section of this form and retain a copy for your records.

Referrals may be emailed to UCCdental@healthmail.ie or posted to –
Dental Referral Management, Cork University Dental School & Hospital, Wilton, Cork

All referrals will undergo clinical triage. **Incomplete referrals will be returned.**
Referrals that do not comply with current CUDSH patient referral protocols will be returned.

Postal enclosures such as radiographs should be dated, of diagnostic quality, marked with the patient's name and DOB and stapled to this form. Where possible, original digital images are preferred to scanned printouts and should be emailed to UCCdental@healthmail.ie.

A leaflet with information for patients wishing to be treated on the **Student Clinic** is available on the CUDSH website.

Urgent	☐
Routine	☐

Referrer Details

Referring Clinician: _____

Practice/Clinic Address: _____

Tel: _____ **Email:** _____ **Postcode:** _____

Patient Details

First Name: _____ **Family Name:** _____

D.O.B. _____ **Parent/Guardian:** _____

Email: _____ **Gender:** _____

Mobile No: _____ **Other Tel:** _____

Patient Address:

_____

_____

_____

_____**Postcode**: _____

Patient's Medical Practitioner

GP Name: _____

Tel: _____ **Email:** _____

Practice Name & Address: _____

_____ **Postcode**: _____

Section A - Refer to Speciality Please tick relevant box(es).		**Section B – Additional Needs** Please tick relevant box(es) and give details below. Completion facilitates appropriate planning for patients.	
Oral Radiology	☐	Complex Medical Needs *(please give details)*	☐
Oral Surgery	☐	Interpreter required *(please state language below)*	☐
Maxillofacial Surgery	☐	Phobic patient	☐
Oral Medicine	☐	Bariatric patient *(BMI > 40 and/or weight > 130kg)*	☐
Paediatric Dentistry	☐	Intellectual Disability *(e.g. impaired ability to comply with dental treatment)*	☐
Restorative Dentistry	☐	Mobility Concern *(e.g. impaired ability to transfer to dental chair or access X-ray Dept.)*	☐
Periodontics	☐	Behavioural Concern *(e.g. impaired ability to comply with dental treatment)*	☐
Prosthodontics	☐	Mental Health Concern *(e.g. impaired ability to comply with dental treatment)*	☐
Endodontics	☐	**Details:**	

Please turn over

Clinical Information

Please complete all sections below. **Incomplete referrals will be returned.**
Continue on a separate sheet if necessary, ensuring that it is marked with the patient's name and DOB.

Section C: Reason for Referral / Clinical Request.

Please include a description of problem / lesion, a provisional diagnosis where possible and any treatment provided to date.
Restorative / Periodontal / Endodontic referrals should be accompanied by a BPE and recent radiographs.

Section D: Medical History / Family History / Social History.

Please include medications and allergies.

Section E: Referral Details.

Has the patient/parent/guardian understood and consented to this referral? Yes ☐ No ☐

Has the patient previously been referred to CUDSH? Yes ☐ No ☐ (If yes, please provide details in Section C above.)

Is the patient agreeable to treatment on the student clinic, if deemed suitable? Yes ☐ No ☐

Section F: Other Relevant Information.

Radiographs attached: Yes (printed) ☐ Yes (emailed) ☐ No ☐

Periodontal charting attached: Yes ☐ No ☐

Signature of Referring Practitioner*(not required for electronic submission)***:** _____ **Date:** _____

Print Name: _____