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 x-rays should be dated, marked with the patient's name and DOB and stapled to this form.
Where possible, original digital images are preferred to scanned printouts.

Urgent	◯
Routine	◯

Referrer Details

Referring Clinician: _____

Practice/Clinic Address: _____

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

Patient Details

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

Date of Birth: _____ **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:**	
Hygiene	☐		

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 referrals should be accompanied by a BPE.

Section D: Medical History, Family History. Social History:
Please include medications and allergies.

Section E: Referral History.

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

Has the patient previously been referred to CUDSH? Yes ☐ No ☐

Section F: Other Relevant Information

Radiographs attached: Yes ☐ No ☐ Periodontal charting attached: Yes ☐ No ☐

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

Print Name: _____