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:

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______________ Postcode: __________

Patient's Medical Practitioner

GP Name: ______________________________

Tel: ______________________ **Email:** ______________________________

Practice Name & Address: ______________________________

______________________________ **Postcode:** __________

Section A - Refer to Speciality

Please tick relevant box(es).

Oral Radiology	☐
Oral Surgery	☐
Maxillofacial Surgery	☐
Oral Medicine	☐
Paediatric Dentistry	☐
Restorative Dentistry	☐
Periodontics	☐
Prosthodontics	☐
Endodontics	☐
Hygiene	☐

Section B – Additional Needs

Please tick relevant box(es) and give details below. Completion facilitates appropriate planning for patients.

Complex Medical Needs *(please give details)*	☐
Interpreter required *(please state language below)*	☐
Phobic patient	☐
Bariatric patient *(BMI > 40 and/or weight > 130kg)*	☐
Intellectual Disability *(e.g. impaired ability to comply with dental treatment)*	☐
Mobility Concern *(e.g. impaired ability to transfer to dental chair or access X-ray Dept.)*	☐
Behavioural Concern *(e.g. impaired ability to comply with dental treatment)*	☐
Mental Health Concern *(e.g. impaired ability to comply with dental treatment)*	☐

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 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: ____