

Cork University Dental School & Hospital: REFERRAL FORM

Please complete both sides and every section of this form and retain a copy for your records.
 Enclosures such as x-rays and periodontal charts should be sealed in an envelope marked with the patient's name and DOB and stapled to this form.
 All referrals will undergo clinical triage. **Incomplete referrals may be returned.**
 Referrals that do not comply with current CUDS&H patient referral protocols may be returned.

Urgent
 Routine



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<p>To: Consultant</p> <p>.....</p> <p>Dental Referral Management</p> <p>Cork University Dental School & Hospital Wilton, Cork</p> <p>Tel: 021- 490 1100</p> <p>Fax: 021- 434 5737 (Restorative Dept)</p> <p>Fax: 021- 490 1179 (Oral Surgery Dept)</p> <p>Fax: 021 490 1192 (Paediatric Dept)</p> <p>Email: dental@ucc.ie</p> <p>Date Referral Letter Received:</p> <p>(please write clearly or Hospital date stamp on receipt)</p>	<p>From: Practice / Clinic (please write clearly)</p> <p>.....</p> <p>Referring Dentist / Clinician</p> <p>.....</p> <p>Practice / Clinic Address:</p> <p>.....</p> <p>Postcode:</p> <p>Tel:</p> <p>Fax no:</p> <p>Email:</p> <p>Dentist / Clinician Signature:</p> <p>Principal Dental Surgeon Signature:</p>
<p>PATIENT DETAILS</p> <p>Full Name:</p> <p>Parent / Guardian:</p> <p>Date of Birth:</p> <p>Daytime Tel:</p> <p>Mobile Tel:</p> <p>Med Card No: Expiry Date:</p>	<p>Patient's Address:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Postcode</p> <p>Health Ins. Yes/No Specify:.....</p>
<p>PATIENT'S MEDICAL PRACTITIONER</p> <p>GP Name:</p> <p>Tel:</p> <p>Fax:</p> <p>Email:</p>	<p>GP Practice Name & Address:</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>Postcode:</p>
<p>Section A - Refer to Speciality Please tick relevant box(es).</p> <p>Dental Radiology <input type="checkbox"/></p> <p>Oral & Maxillofacial Surgery <input type="checkbox"/></p> <p>Oral Medicine <input type="checkbox"/></p> <p>Paediatric Dentistry (incl. child with special needs) Please complete section B <input type="checkbox"/></p> <p>Special Needs / Care Dentistry (adults) Please complete section B <input type="checkbox"/></p> <p>Orthodontics (Currently only HSE referrals) Specialist form to be completed and attached <input type="checkbox"/></p> <p>Restorative Dentistry <input type="checkbox"/></p> <p>Periodontics <input type="checkbox"/></p> <p>Prosthodontics <input type="checkbox"/></p> <p>Endodontics <input type="checkbox"/></p>	<p>Section B - Special Needs / Care Dentistry Please tick box(es) that are applicable to this referral.</p> <p>Mental Health <input type="checkbox"/></p> <p>Learning Disability <input type="checkbox"/></p> <p>Uncooperative <input type="checkbox"/></p> <p>Hoist or bariatric facility <input type="checkbox"/></p> <p>Phobic Adult - ASA I or II <input type="checkbox"/></p> <p>Special medical needs (medically compromised) - ASA II or III <input type="checkbox"/></p>

Patient Name: _____ **DOB:** _____ **Referring GP/GDP:** _____

ADDITIONAL CLINICAL REFERRAL INFORMATION

Please complete all sections below. For those not applicable to the referral please put in **N/A**.

If any sections are blank the referral may be returned, delaying the patient's treatment.

If you do not have sufficient room please continue on a separate sheet quoting the patients name and DOB along with the relevant section letter that the additional information applies to in order to avoid any confusion.

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Section C: Clinical reason for referral – provisional diagnosis / treatment – description of problem / lesion :
Restorative / Periodontal referrals should be accompanied with a BPE.

Section D Relevant medical history – current medication - ALLERGIES : Relevant family / social history:

PATIENTS PAST DENTAL REFERRAL HISTORY

Previous Dental Referral No Yes If yes, please complete the following

Date of last dental referral: **Where patient was treated :** **Reason for last referral:**

.....

PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT

Has the patient understood and consented to the referral? Yes No

Section E: Any other relevant information or current treatment plan associated with this referral:

ATTACHMENTS - appropriate radiographs are essential.

Radiographs attached: tick if yes Periodontal charting attached: tick if yes

Signature of Referring Practitioner: **Date:**

Print Name:

Please check that all sections are complete to prevent the possible return of this referral.

For CUDSH use only: Date Patient Registered: CDS No:.....

Referral forwarded to Consultant: Triage outcome: Urgent Soon Routine