GIG CYMRU NHS WALES | Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Please refer to Pg3 for guidance notes and where to send your referral.

CHILD ORAL HEALTH CARE & GA REFERRAL (ages 3-17 YRS)

Age of Patient in Years:	Patient's Title & Name:	Sex	Date of Birth (DD/MM/YY) / /
Patient's Address:			
Patient's Town or City:	Preferred Contact No:		Patient's Postcode

Referrer's Name:	Practice Postcode:	Date of Decision to refer / /	Interpreter required? YES / NO Language?
Practice Name and Address:			Practice Phone Number:
GDC Number:	Care Type (Routine or Urgent)		Has child had dental extractions under GA in the past:
If Urgent Care please state why:			

Patient's School or Nursery Address: [This information is essential and referrals will be rejected without it]

Patient's GP Name and Address including Postcode:

Patient's principle complaint:	Previous dental history incl. experience with local anaesthetics and date:

Main Reason for Routine Referral:

- ☐ FAILED GA TREATMENT ☐ OTHER: (Specify)
- ☐ REFUSED LA
- ☐ UNCOOPERATIVE
- ☐ ANXIOUS/PHOBIC
- ☐ FAILED SEDATION

Main Reason for Urgent Referral: (Guidance on pg3)

- ☐ PAIN
- ☐ SEVERE INFECTION
- ☐ OTHER (Specify):

PLEASE ATTACH RADIOGRAPHS/ORTHODONTIST LETTER AS REQUIRED. SCHOOL OR NURSERYNFORMATION IS FOR SAFEGUARDING

TICK THE BOX TO CONFIRM THE CONTINUING CARE & PREVENTION LEAFLET HAS BEEN COMPLETED WITH THE LEGAL GUARDIAN AND THAT CONTINUING CARE WILL BE OFFERED TO THE PATIENT IRRESPECTIVE OF THIS REFERRAL. PLEASE ATTACH COMPLETED LEAFLET WITH REFERALL ☐

Suggested Treatment Plan: For extractions, please indicate below the teeth / roots to be removed with an X, for restorations or endodontics indicate F

PERMANENT DENTITION

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8		6	5	4	3	2	1	1	2	3	4	5	6	7	8

PRIMARY DENTITION

E	D	C	B	A	A	B	C	D	E
E	D	C	B	A	A	B	C	D	E

Please state what attempts have been made to treat child in primary care? Must be completed

I have read and understood the guidance notes for making routine/urgent referrals.

SIGNED:____

PLEASE COMPLETE A CHILD MEDICAL HISTORY FORM – ENSURE ALL BOXES ABOVE COMPLETED -ADDITIONAL INFORMATION / LETTERS ETC MAY ACCOMPANY THE REFERRAL BUT MUST REFERENCE THE PATIENT NAME & DOB

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This a medical history form. This should be completed in combination with a referral form .

CHILD (3-17) MEDICAL HISTORY FORM

Before you begin a referral:

Please ensure that you have read and understood the referral guidelines; referrals not completed appropriately **will be returned to you**. Ensure all necessary attachments are sent with referral.

DO NOT SEND A BLANK FORM – STATE NAD IN EACH BOX IF NECESSARY

PATIENT NAME & DOB:	**THIS FORM SHOULD BE SUBMITTED WITH THE REFERRAL FORM.**

MEDICAL ALERT – Please note here anything of particular importance in the medical history and their impact on delivering care within a regular primary care setting.

CARER – Please tell us if this patient will attend with a carer – please provide details of the carers contact details here:

DOES THE PATIENT HAVE / SUFFER FROM / CURRENTLY EXPERIENCING

- ☐ **NONE OF THE BELOW**
- ☐ RECIEVEING TREATMENTFROM A DOCTOR, HOSPITAL OR CLINIC
- ☐ PREGNANT,POSSIBLY PREGNANT OR BREASTFEEDING D
- ☐ USING A MOBILITY AID E.G. WHEELCHAIR
- ☐ CONGENITAL HEART DEFECT
- ☐ HEART DISEASE
- ☐ HEART MURMUR NOT DIAGNOSED AS INNOCENT
- ☐ PACEMAKER
- ☐ BRONCHITIS ASTHMA,OTHER CHEST COMPLAINT
- ☐ LIVER OF KIDNEYS (CIRRHOSIS,JAUNDICE,HEPATITIS)
- ☐ INFECTIOUS DISEASE(HEPATITIS, HIV,TB, CJD)
- ☐ ANEMIA
- ☐ BLOOD OR BLEEDING DISORDER
- ☐ GASTROINTESTINAL DISORDER
- ☐ ALLERGY - PLEASE SPECIFY BELOW
- ☐ A STROKE
- ☐ SWALLOWING OR CHOKING PROBLEMS
- ☐ OTHER - PLEASE SPECIFY BELOW
- ☐ LEARNING DISABILITY
- ☐ ADHD- BEHAVIOURAL DISORDER
- ☐ AUTISM
- ☐ ACQUIRED BRAIN INJURY
- ☐ PSYCHIATRIC DISORDERS
- ☐ EPILEPSY, FAINTING
- ☐ SKIN PROBLEMS
- ☐ DIABETES
- ☐ TAKING PRESCRIBED/NON PRESCRIBED MEDICATION
- ☐ BAD REACTION TO GENERAL, LOCAL ANESTHESIA, SEDATION
- ☐ NEUROMUSCULAR DISORDER
- ☐ EATING DISORDER
- ☐ OBESITY
- ☐ SYNDROME-PLEASE SPECIFY BELOW

PLEASE PROVIDE DETAILS OF ANY CONDITION INDICATED ABOVE INCLUDING ASSESSMENT OF SEVERITY AND IMPACT ON DELIVERING CARE:

MEDICAL ALERTS

- ☐ EPILEPSY
- ☐ DIABETES
- ☐ ALLERGIES
- ☐ STERIOD TREATMENT
- ☐ SICKLE CELL ANEMIA
- ☐ THALASSAEMIA
- ☐ MEDICAL ALERT / BRACELET (DESCRIBE)

PLEASE LIST ANY ALLERGIES HERE

MOBILITY ISSUES

- ☐ WALKS UNAIDED
- ☐ WALKS AIDED
- ☐ WHEELCHAIR USER

DESCRIBE WHAT ASSISTANCE IS REQUIRED:

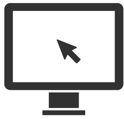
IF CURRENTLY, OR PREVIOUSLY, UNDER HOSPITAL CARE, PLEASE STATE NAME OF PAEDIATRICIAN AND HOSPITAL ATTENDED

PLEASE PROVIDE DETAILS OF ANY PRESCRIBED MEDICINES HERE. YOU MAY ATTACH FURTHER DETAILS TO THIS FORM AS REQUIRED

How to send your referral to us:

Post your referral to:
Dental Co-ordinator, Single Point of Access Room, Port Talbot Resource Centre, Moor Road, Port Talbot, SA12 7BJ.

Post Urgent Referrals to:
Parkway Clinic, Lamberts Road, SA1 Waterfront, Swansea, SA1 8EL



For help, advice & support:
Abm.Dentalspa@wales.nhs.uk or for specific information on an urgent referral contact Parkway Clinic: sian@parkwayclinic.co.uk

For help, advice & support:
Call the SPA on (TBC) or for specific advice on an urgent referral made to Parkway Clinic call 01792 455780.

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Please talk to us. The best way to get immediate help and advice is to email us at ABM.Dentalspa@wales.nhs.uk

PAEDIATRIC REFERRAL NOTES & GUIDANCE

Guidance for an Urgent Treatment Referral:

• All urgent patients e.g. with acute and significant dental infection and associated symptoms, requiring extraction under GA/conscious sedation should be offered an appointment for assessment and treatment within 48 hours of the date of the receipt of the referral.

• Where treatment under conventional local anaesthetic is considered inappropriate or has failed, the following criteria may be used as indicators to consider a paediatric patient for referral for urgent dental treatment under the service:

1.Significant and worsening ora-facial swelling and where systemic illness or pyrexia may also be evident.
2.Severe acute dental pain not controlled by over the counter medication.

Referrals are not accepted for:

- Routine primary care (e.g. caries in cooperative children, endodontic treatment in permanent teeth with closed apices).
- Root canal treatment in permanent molars unless there is good clinical indication for retention of the compromised tooth i.e. severe hypodontia.
- Routine (premolar) orthodontic extractions under GA.

Access to the Paediatric Dentistry GA or sedation services.

Referrals for extractions under General Anaesthesia or sedation, should follow the guidelines published by the GDC in Maintaining Standards. Guidance to Dentists on Professional and Personal Conduct. 1997; Paragraph 4.18;

"Clear justification for the use of General Anaesthesia, together with details of the relevant medical and dental histories, must be contained in the referral letter".

Further details, resources and information on the website.

Inappropriate / inadequate referrals **will be returned**. Your compliance with the above guidelines will avoid unnecessary delays in patient care.

Thank You.