Logo, company name

Description automatically generated

**SND Specialist**

Dr Hajer Derbi

Provider Number: 4867926F

43 Blackburn Rd

PO Box 89

Blackburn VIC 3130

[admin@specialneedsdental.com.au](mailto:admin@specialneedsdental.com.au)

Tel: (03) 9877 8035

Fax: (03) 9878 1831

ABN: 68 569 736 700

REFERRAL FORM

The following information is requested for registration, risk assessment and treatment planning.

If it is incomplete, the patient’s dental treatment may need to be delayed until the required information is obtained.

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** | | | |
| Name |  | UR number |  |
| DOB |  | Gender |  |
| Address |  | | |
| Tel/Mob |  | Email |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Referrer details** | | | |
| Name |  | Position |  |
| Organisation / Address |  | | |
| Email / phone / fax |  | | |
| Date of referral |  | | |

|  |  |  |
| --- | --- | --- |
| **Reason for referral (please tick all that apply)** | | |
| Check-up and preventive care  Pain, infection, trauma  Oral hygiene, diet or saliva concerns  Specific dental problem (tooth, denture, gums)  Jaw problems or tooth grinding  Behavioural challenges  Treatment plan / Care support coordination  Second opinion / Advice | Specific concerns: | |
| **Does the patient have any of the following:** | | **Does the patient require completion of dental treatment within a certain timeframe?** |
| Inability to provide self-consent   * Medical tx decision maker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Uncooperative behaviour   * Sedation required: yes/no   Communication aids   * Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Dysphagia   * Modified diet: soft/minced/pureed/no * Thickened fluids: mild/moderate/extremely/no * PEG: yes/no * Nil by mouth: yes/no   Uncontrolled jaw movements or limited mouth opening  Needs help with toothbrushing   * Prompting * Modified/electric toothbrush * Carer assistance * Rejects assistance   Bed/Wheelchair-bound  Palliative care needs | | No  Yes – please specify: |
| **Do you require a report from the dentist?** |
| No  Yes – please specify information required and when it is required by: |
| Preferred method of communication:  Letter  Email  Phone  Consult |
| **Patient authority to release dental records to a second practitioner** |
| I hereby give by authority for records regarding my medical/dental treatment to be forwarded to the Special Needs Dental Team, to whom I have been referred for further consultation and/or course of care.  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_ |

**PLEASE ATTACH (where applicable)**

* Patient registration form Attached Not available
* Dental history, OPG, intra-oral radiographs (with dates) Attached Not available
* Summary of current and past medical conditions Attached Not available
* Current medication list Attached Not available
* Specialist reports Attached Not available Not applicable
* Advanced care directive Attached Not available Not applicable
* Home oral care plan Attached Not available Not applicable
* Behavioural support plan Attached Not available Not applicable
* NDIS plan Attached Not available Not applicable

**FOR DENTAL OFFICE USE:**

**Further records required**

Osteoporosis Antiresorptive medication history

Diabetes: HbA1c

Bleeding disorders: FBE, INR, platelet count, factor levels

Kidney & liver disorders: U/E, LFTs

Chemotx/immunosuppressants: FBE

Radiotherapy: Date, dose, radiation field maps

Specialist reports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allied health reports: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital discharge summary \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GA records: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_