

**SND Specialist**

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]