**Please complete and post to: Patient Administration Team, Bristol Dental School, 1 Trinity Quay, Avon Street, Bristol, BS2**

|  |  |  |
| --- | --- | --- |
| **ACCEPTANCE CRITERIA** | | |
| Please be aware of our patient acceptance criteria, our sole purpose is clinical education and training, and therefore will reject any referrals that do not meet the needs of our students. Our acceptance criteria can be found [here](https://www.bristol.ac.uk/dental/)  .  The school will accept patients whose restorative treatment needs can be carried out under routine local anaesthetic and falls under the category level 1 (care that is expected by a general dental practitioner in primary care). On completion of treatment the patient will be referred back to your care with a report of treatment provided for ongoing maintenance under your care.  **Please note: We have specific referral forms for Dentures, Endodontics, Periodontics. This form should be used for referrals for all other general restorative treatments.** | | |
| **TRIAGE INFORMATION (FOR BRISTOL DENTAL SCHOOL USE ONLY)** | | |
| Is this referral for: *(please tick)*  **A)**  **Suitable for U/G Assessment**   **B) Not Suitable** | | |
| **PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** | | |
| Has the patient understood and consented to the referral and is happy (if accepted) for treatment to be delivered by oral health care professionals undergoing training?  YES | | |
| **REASON FOR REFERRAL** | | |
| **PROVISIONAL DIAGNOSIS.** | | |
| **TREATMENT HISTORY.** Please detail. | | |
| **Standing teeth:** *please circle standing teeth*   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | **BPE Score:**   |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | | |
| **RADIOGRAPH** | | |
| Is a diagnostically acceptable **RADIOGRAPH** included with this referral?  Date taken | YES  NO  Reason if not | |
| **MEDICAL HISTORY/SOCIAL DETAILS** | | |
| |  |  | | --- | --- | | **Medical Conditions: Tick box 1if none. Complete if other.**  **1. No relevant medical history confirmed**    **Current Medication:**  **Bisphosphonates/Denosumab state no of years……..** | **Tick ALL relevant boxes**  **Warfarin\* stable INR below 3.5**  **NOACs e.g. rivaroxaban**  **Aspirin/Clopidogrel**  **Bleeding disorders**  **Bisphosphonates (oral)**  **Bisphosphonates (IV)**  **DMARDS (Drugs for rheumatoid conditions)**  **Oral Steroids**  **Uncontrolled Diabetes**  **Cardiac Valve replacement**  **Immunosuppressant’s**  **Chemotherapy** | | | |
| **MEDICATION LIST -** Please state type and dosage details. Or attached prescription.  **YES**  please detail. **NONE** | | |
| **ALCOHOL COMSUMPTION YES**  Number of units a week. **NONE** | | |
| **SMOKER/VAPOUR/EX SMOKER YES**  Number of years and number per day. **NO**  *(delete as required)*  Where appropriate, patients who smoke should be encouraged to cease the habit on the basis that treatment outcome, e.g. Perio, is often poor | | |
| **ALLERGIES -** Please state allergy and description of reaction, if known. **YES**  please detail. **NONE** | | |
| **OTHER INFORMATION** (E.g. Living arrangements, Legal guardian) | | |
| **FULL PATIENT DETAILS** | | **GDP (REFERRER) DETAILS** |
| Mr  Mrs  Miss  Ms  Dr  Other  Male  Female  NHS Number:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Mobile Number:  E-mail Address: | | Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Job Title:  GDC Number:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: |
| **PATIENT GMP DETAILS** | | **COMMUNICATION & SPECIAL REQUIREMENTS** |
| Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | | Does the patient communicate in a language or mode other than English?  YES  please detail. NO  Is an interpreter required? YES  please detail. NO  Does the patient have any special requirements? YES  please detail. NO |
| **CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER** | | |
| Has the patient understood and consented to the referral and is happy (if accepted) for treatment to be delivered by oral health care professionals undergoing training?  YES  NO | | |
| **Print Full Name:………………………………………………………………………………………………… Date:………………………….................**  **Signature: ………………………………………………………………………………** | | |