**Smile Together Referral Form for Health Visitors**

Please read the Guidance notes before completing this form

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| **1 - Patient Details** |
| **Title:** Choose an item. | **First Name** |  |
| **Middle Name(s)** |  |
| **Last Name** |  |
| **Gender** |  Choose an item. |
| **DOB** |  |
| **NHS Number** |  |
| **Address (inc. Postcode)** |  |
| **Contact Telephone Number(s)** | **Landline** |  |
| **Mobile** |  |
| **Main Medical Conditions** |  |
| **List of Medications** |  |
| **Allergies** |  |
| **2 – Main Parent/Guardian/Carer Details** |
| **Title: Choose an item.** | **First Name** |  |
| **Last Name** |  |
| **Address (inc. Postcode)** |  |
| **Contact Telephone Number(s)** | **Landline** |  |
| **Mobile** |  |
| **3 – GDP Details** |
| **GP’s Name** |  |
| **Practice Address (inc. Postcode)** |  |
| **Practice Telephone Number** |  |

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| **4a – Additional Needs – Communication***Please tick all that apply to the child or family members and please attach any additional information if this does not allow you to describe fully the child’s needs.* |
| **Does the child or Family member(s) have any communication or information needs?** Yes [ ]  No [ ]  |
| **Is Accessible information required?** Yes [ ]  No [ ]  |
| **What Can be provided to support communication?** Large Print [ ]  Easy Read [ ]  Braille [ ]  BSL [ ]  |
| Other[ ]  |  |
| **4b – Additional Needs – Language**  |
| **Is an interpreter needed?** Yes [ ]  No [ ]  |
| **If yes, which language is needed?** |  |
| **5 – Main Reason for Referral** |
| **Vulnerable Child** [ ]  | **Older Siblings who have had dental extractions under general anesthetic within 5 years** [ ]  |
| **Other** [ ]  | **If other, please describe here:** |
| **6 – Dental Problems and Concerns** |
| Why does this Child need to be seen by Special Care Services and not a general dentist? |  |
| Are they currently taking any medication for a dental problem? | Yes [ ]  No [ ] If yes, please specify the medication below: |
| Are there any other Dental Concerns about this child’s mouth? | Yes [ ]  No [ ] If yes, please specify below: |

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| **6 – Details of the person making the referral** |
| **Name of the person making the referral** |  |
| **Job Title** |  |
| **Contact E-mail Address** |  |
| **Contact Telephone Number** |  |
| **Postal Address (inc. Postcode)** |  |
| **Signature** |  |
| **Date:** Click or tap to enter a date. |

Please tick to confirm you have told the parents and/or relatives, carer where appropriate you are making this referral [ ]

Please tick to confirm this referral complies with the General Data Protection Regulation, so that information can be shared with other Health and Social Care Professionals if this is necessary and, in the Patient’s, Best Interest [ ]

**For Health Visitors completing this referral - please send this completed form to the Referral Management Centre E-mail:** ciosicb.rmsdentalreferrals@nhs.net