Southern Health and Social Care Trust
Quality Care - for you, with you

COMMUNITY DENTAL SERVICE
REFERRAL / MEDICAL HISTORY
PLEASE PRINT IN BLACK PEN

PLEASE NOTE IF ANY SECTION OF THIS FORM IS NOT COMPLETED IT MAY BE SENT BACK TO REFERRER

DATE OF REFERRAL:	PATIENT'S HEALTH & CARE NUMBER (TEN DIGITS)

REFERRED BY: NAME ADDRESS TELEPHONE NUMBER (PLEASE PRINT CLEARLY)	

PATIENT NAME: _____ DOB: _____ MALE / FEMALE

PATIENT ADDRESS: _____

_____ POSTCODE: _____

ETHNICITY: _____ MOBILE: _____

NAME OF NEXT OF KIN: _____ RELATIONSHIP: _____

ADDRESS (IF DIFFERENT FROM ABOVE): _____

DAYTIME TEL NO: _____ MOBILE: _____

GP (NAME, ADDRESS, TELEPHONE NO.)	
PAEDIATRICIAN, SPECIALIST, SOCIAL WORKER, OTHER; (NAME, ADDRESS, TELEPHONE NO.)	
INTERPRETER NEEDED? YES / NO	LANGUAGE:
TREATMENT REQUESTED:	
REASON NOT ABLE TO BE TREATED IN GENERAL DENTAL PRACTICE:	
PREVIOUS DENTAL HISTORY: - TREATMENT ATTEMPTED - HAS THIS PERSON HAD PREVIOUS TREATMENT IN CDS?	
RELEVANT SOCIAL HISTORY:	

RADIOGRAPHS MUST BE PROVIDED FOR ALL PERMANENT TEETH TO BE TREATED

RADIOGRAPHS PROVIDED (PLEASE CIRCLE) IOPA B/W OPG OTHER

MEDICAL HISTORY OVERLEAF TO BE COMPLETED AND SIGNED BY REFERRER

PATIENT NAME_____ **DOB:** _____

HAVE YOU EVER HAD / ARE YOU CURRENTLY EXPERIENCING:-	YES	NO	DETAILS
Any chest or breathing complaint (e.g. Asthma, bronchitis)?			
Cardiac problems (angina, stroke, blood pressure, heart murmur, heart surgery, aortic valve stenosis or aortic stenosis)?			
Swallowing difficulties?			
Diabetes (specify average blood sugar results)?			
Epileptic seizures / convulsions / blackouts / fainting? (CDS to complete rescue medication form if appropriate)			
Do you or any family members suffer from bleeding disorders or genetic blood disorders (e.g. sickle cell disease, haemophilia)?			
Any kidney or liver disorder (e.g. hepatitis, jaundice)?			
Learning disability, physical, sensory or behavioural issues?			
Mental health issues?			
Visual, hearing, memory impairment or communication difficulties?			
Are you a wheelchair user or do you have any mobility issues?			
Are there any conditions that run in your family?			
Infectious conditions, such as MRSA, HIV, Hepatitis, TB?			
Have you / members of your family or a relative been diagnosed as suffering from definite, probable or possible CJD or vCJD?			
Is there a possibility you could be pregnant?			
Do you / did you ever smoke cigarettes/e-cigs or other tobacco products? How many per day?			
Do you drink alcohol? How many units a week? (2 units = 1 pint or 1 glass of wine or 1 shot)			
List any pills, drugs (including recreational) medication (including herbal products) inhalers, ointments and injections taken now or in recent months?			
Taken bisphosphonates (bone medications) now or in the past?			
Allergy to anything? Do you carry an Epipen?			
Are you attending a doctor / hospital / clinic for any reason?			
Has there been, or is there currently, any social care involvement?			
Have you ever had a general anaesthetic?			
Have you or any relatives had problems associated with a general anaesthetic?			
Are there any other risks / issues that we should be informed of, any other illnesses / conditions / phobias?			

PLEASE NOTE THAT THIS INFORMATION MAY BE SHARED WHERE APPROPRIATE WITH OTHER RELEVANT PARTIES

DENTIST SIGNATURE TO VERIFY MEDICAL HISTORY:	**DATE:**
DENTIST SIGNATURE TO VERIFY MEDICAL HISTORY:	**DATE:**
DENTIST SIGNATURE TO VERIFY MEDICAL HISTORY:	**DATE:**

CDS Office Use:	Height: cm	Weight: Kg	BMI:	POC: