Date of Referral:	Dental Clinic

Community Dental Service

(CDS) Referral Form

Please complete **ALL** sections of the form - **Incomplete forms will be RETURNED**

Patient Details **Name: DOB:** **Gender** **Address** **Postcode:** **Tel No:** **NHS No**:	**General Medical Practitioner** Name: Address: Postcode: Tel No:
Next of Kin/ Carer Name: Address: Postcode: **Tel No** Relationship to patient:	**Referred by** Name: Position/ relationship: Address: Postcode: Tel No:

Indicators for a referral to CDS (please tick all that apply)

- ☐ Learning disabilities
  Mental health problems
- ☐ Physical disabilities
- ☐ Complex medical history (please expand in medical history section)
  Person in rehabilitation, secure unit, homeless
- ☐ Complete inability to leave home to seek care due to a form of disability
- ☐ Assessment for sedation
- ☐ Other, please state_____

Special Care requirements e.g.

- ☐ Need for a hoist
- ☐ Language line
- ☐ Bariatric patient
- ☐ Adapted wheelchair Use

<u>This box must be completed or the referral will be returned</u>

Reason for referral - dental history

Please include information about:

Medical History

Has the patient been seen by the CDS before: Yes □ NO

Please return form to: CTM_cdsreferrals_BGD@wales.nhs.uk

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