**Community Dental Service (CDS) Referral Form**

|  |  |  |
| --- | --- | --- |
| Date of Referral: |  | Dental Clinic |

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

**This box must be completed or the referral will be returned**

|  |
| --- |
| **Reason for referral - Please include as much information about previous dentistry as possible:** |

Has the patient been seen by the CDS before: Yes ▢ No ▢

A Medical History Form must be included: ▢

**Please return forms to**: [CTM.cdsreferrals.KHHP@wales.nhs.uk](mailto:CTM.cdsreferrals.KHHP@wales.nhs.uk)

**Dental Department**

**Keir Hardie Health Park**

**Aberdare Road**

**Merthyr Tydfil**

**CF48 1BZ**