County Durham and Darlington NHS
NHS Foundation Trust

Referral Guideline for Community Specialist Dental Service

Version 2

Date: February 2023

County Durham and Darlington NHS
NHS Foundation Trust

Appendix 1: Community Specialist Dental Service Referral Form
Referral from: GENERAL DENTAL PRACTITIONER (GDP)

Please check our **Referral Guidelines** to ensure the referral is appropriate for the remit of our service. Complete the form in full as failure to do so will delay the referral process. Send by email: cddft.communitydental@nhs.net or post to the clinic nearest to patient's postal address.

❑ **Adult Patient Referral** ❑ **Child (15 years and under) Patient Referral**

Patients Details

Surname: First Name:

Date of Birth: Sex: M / F

Address:

Postcode: Contact Tel:

Dental Practice Address	**Referring Dentist Name:** **GDC No:** Practice Tel. No: Date:

Carer Details (if applicable)

Parent/Guardian/Carer:

Contact No: Relationship to patient:

General Medical Practitioner

Name: Contact No:

Address:

Reason for Referral - details must be provided for all that apply

❑ Complex/unstable medical condition (provide full details in medical history section)

❑ Learning Disability/Autism/Cognitive impairment, details:

❑ Physical/Mobility issues, details:

❑ Mental Health problems, details:

❑ Dental Anxiety/problems with co-operation* details:

***(Ensure does not meet Tier 1 or 2 Sedation criteria and include evidence of why treatment has not been provided and a completed MDAS form.)**

❑ Looked after child/social problems, details:

❑ Other, please specify:

Further Information (complete all sections):
Known history of dependency drugs/alcohol No ❑ Yes ❑ **Details:**

Interpreter required Yes ❑ **Language:** **Patient Height:** **Weight:**

Known history of challenging/violent/intimidating or inappropriate behaviours No ❑ Yes ❑
Details:

(If **'Yes'** please notify patient/carers that they will be contacted to complete risk assessment prior to first appointment)

Has the patient previously had treatment within our Dental Service? No ❑ Yes ❑

If Yes, please give date: Clinic

Is the patient suffering dental pain? No ❑ Yes- mild/intermittent ❑ Yes-severe/continuous ❑	**Have antibiotics been required?** No ❑ Yes ❑ number courses:.........

Medical History (please provide information of all medical conditions, attach separately if required)

Prescribed Medications:

Known Allergies No ❑ Yes ❑
details:..

Details of Patient Co-operation
Has a dental examination been possible with the patient lying supine? No ❑ Yes ❑

Please state what treatment has been undertaken/attempted:
……………………..............................

Which aspects of treatment is the patient unable to tolerate?
❑ Air/water/suction ❑ Sensation of instruments ❑ Local Anaesthetic ❑ X-rays

❑ Other, details:

Suggested Treatment Plan

Teeth for extraction:

Teeth for restoration:

Other
Treatment:..

Radiographs <u>must</u> be included for all teeth requiring treatment, be less than 12 months old and diagnostic quality. Please attach or email to cddft.communitydental@nhs.net

For children bitewings should accompany each referral, also an OPG if patient is in mixed dentition.

If radiographs are not available, why was this not possible?......................................

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Appendix 2: Community Specialist Dental Service Referral Form

Referral from: OTHER HEALTH or SOCIAL CARE PROFESSIONALS

Please refer to our **Referral Guidelines** to ensure the referral is appropriate for the remit of our service. Complete the form in full as failure to do so will delay the referral process. Send by email: cddft.communitydental@nhs.net or post to the clinic nearest to patient's postal address.

❑ **Adult Patient Referral** ❑ **Child (15 years and under) Patient Referral**

Patients Details

Surname: First Name:

Date of Birth: Sex: M / F

Address:

Postcode: Contact Tel:

Carer Details (if applicable)

Parent/Guardian/Carer:

Contact No: Relationship to patient:

General Medical Practitioner

Name: Contact No:

Address:

Reason for Referral - details must be provided for all that apply

❑ Complex/unstable medical condition (please attach full medical history)

❑ Learning Disability/Autism/Cognitive impairment, details:

❑ Physical/Mobility issues, details:

❑ Mental Health problems, details:

❑ Dental Anxiety/problems with co-operation, details:

❑ Looked after child/social problems, details:

❑ Other, please specify:

Further Information (complete all sections):
Known history of dependency drugs/alcohol No ❑ Yes ❑ **Details:**

Interpreter required Yes ❑ **Language** **Patient Height:** **Weight:**

Known history of challenging/violent/intimidating or inappropriate behaviours Yes❑ No ❑

Details:

(If **'Yes'** please notify patient/carers that they will be contacted to complete risk assessment prior to first appointment)

Care Coordinator's Details

Name Contact Tel:

Email:

Address:

Social Worker Details (if applicable) Name: Tel:

Next of Kin Details (if applicable) Name: Tel:

Does the patient have any dental/oral pain?

❑ Yes-severe/continuous ❑ Yes-mild intermittent ❑ No ❑ Don't know

Tolerance/Co-operation Problems
Are there any aspects of a dental appointment which the patient may be unable to tolerate or find distressing, resulting in unusual or challenging behaviour?

❑ Loud noises ❑ Bright lighting ❑ Smells tastes or textures ❑ Being touched

❑ Movement of dental chair ❑ Prolonged waiting

❑ Other (please state)

Attachments Required

❑ Full Medical History, including medication and known allergies

❑ Behaviour Plan (if applicable)

❑ Disability Distress Assessment Tool (if applicable)

Referring Health, Social Care or Educational Professional

Name: Job Title:

Email:

Address:

Contact Number: Date:

Appendix 3

Modified Dental Anxiety Score Questionnaire

To be completed for all patients >12 years old referred with dental anxiety and include with referral letter.

CAN YOU TELL US HOW ANXIOUS YOU GET, IF AT ALL, WITH YOUR DENTAL VISIT?

PLEASE INDICATE BY INSERTING 'X' IN THE APPROPRIATE BOX

1. **If you went to your Dentist for TREATMENT TOMORROW, how would you feel?**

   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

2. **If you were sitting in the WAITING ROOM (waiting for treatment), how would you feel?**

   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

3. **If you were about to have a TOOTH DRILLED, how would you feel?**

   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

4. **If you were about to have your TEETH SCALED AND POLISHED, how would you feel?**

   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

5. **If you were about to have a LOCAL ANAESTHETIC INJECTION in your gum, above an upper back tooth, how would you feel?**

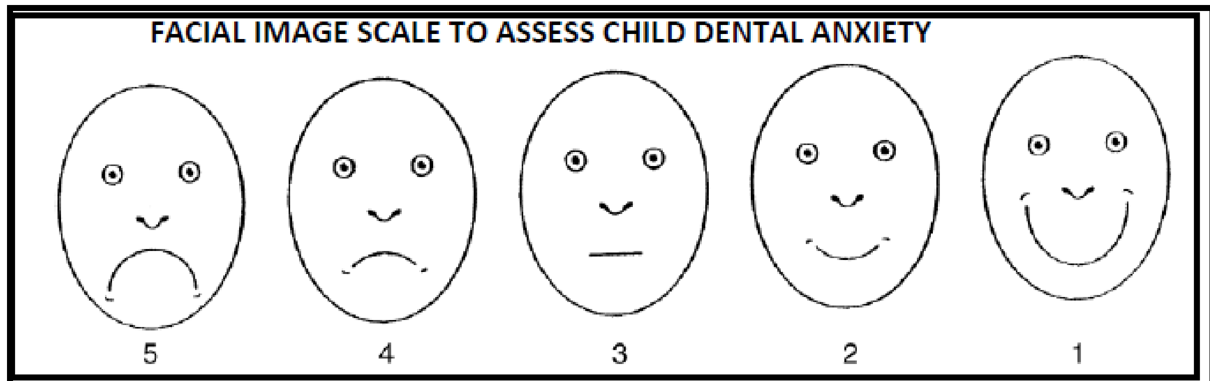
   Not Anxious ☐ *Slightly Anxious* ☐ *Fairly Anxious* ☐ *Very Anxious* ☐ *Extremely Anxious* ☐

Appendix 4

Modified Dental Anxiety Score Questionnaire
For Children

To be completed by children <12years old referred with dental anxiety.

Please ask the child to point to the picture that best represents how they feel about receiving dental treatment. Circle the image selected and include completed form with patient referral



Appendix 5

Principle Clinic Addresses for Patient Referral Letters

Please send referral letter to the closest principle clinic to the patient's home address.

Bishop Auckland
Dental Department - 2nd Floor
Bishop Auckland Hospital
Cockton Hill Road
BISHOP AUCKLAND
DL14 6AD

Tel: 01388 455767

Stanley
Dental Department
Stanley Primary Care Centre
Clifford Road
STANLEY
DH9 0AB

Tel: 01207 285565

Chester Le Street
Dental Department
Chester le Street Community Hospital
Front Street
Chester Le Street
DH3 3AT

Tel: 0191 3876305

Darlington
Dental Department
Park Place Health Centre
DARLINGTON
DL1 5LW

Tel: 01325 342150

Appendix 6

All Community Specialist Dental Service Clinic Sites

****Please only send referrals to the principle clinics listed in Appendix 5****

Bishop Auckland
Dental Department - 2nd Floor
Bishop Auckland Hospital
Cockton Hill Road
BISHOP AUCKLAND
DL14 6AD

Tel: 01388 455767

Stanley
Dental Department
Stanley Primary Care Centre
Clifford Road
STANLEY
DH9 0AB

Tel: 01207 285565

Darlington
Dental Department
Park Place Health Centre
DARLINGTON
DL1 5LW

Tel: 01325 342150

Chester Le Street
Dental Department
Chester le Street Community Hospital
Front Street
Chester Le Street
DH3 3AT

Tel: 0191 3876305

Barnard Castle
Dental Department
Richardson Community Hospital
Victoria Road
Barnard Castle
DL12 8HW

Tel: 01833 696586

Chester Le Street
Dental Department
Chester le Street Community Hospital
Front Street
Chester Le Street
DH3 3AT

Tel: 0191 3876305

University Hospital North Durham
Dental Department
University Hospital North Durham
North Road
Durham
DH1 5TW

Tel: 01207 285565

General Anaesthesia provided:

University Hospital North Durham

Darlington Memorial Hospital

Bishop Auckland Hospital (children only)