

Dental Services Priority Groups Referral

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|--|--|--------------|-------------|-----------------|--|
| Patient Name | | | | | |
| CHI (DOB if unknown) | | | | | |
| Address | | | | Postcode | |
| Telephone Number(s) | | | | | |
| Email Address | | | | | |
| Patient's details cross checked on | EMIS | Y / N | TRAK | Y / N | |
| Welfare Guardian or relevant other (if known) | | | | | |
| Relationship to Patient | | | | | |
| Welfare Guardian or relevant other Telephone Number (s) | | | | | |
| Patient / Welfare Guardian's (or relevant other's) consent gained for referral to be given to Oral Health Department | | | | Y/ N | |
| Reason for Referral Tick All That Apply | Missed Dental Appointment(s) / Was Not Brought Oral Health Advice/Support Domiciliary Eligibility Assessment Other: | | | | |
| Missed Dental Appt(s) (If applicable) | No. & Type of missed appt(s): | | | | |
| | Treatment outstanding: | | | | |
| Oral Health Advice/Support Please provide any specific relevant information including oral health discussions already had with patient / welfare guardian or relevant other / care provider. | | | | | |

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|---|--|-----------------|--|
| Domiciliary Eligibility Assessment Please provide any specific relevant information including any discussion already had with patient/ welfare guardian or relevant other /care provider. | | | |
| Any other relevant information e.g. any other professionals involved with supporting patient. | | | |
| Is patient registered with a dentist | | Yes / No | |
| Dentists Name & Practice Address (If known) | | | |

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|---------------------------------------|--|--------------------|--|
| Referrer | | Designation | |
| Base Address | | | |
| Contact Details (Tel/Email) | | | |

| | |
|--------------|--|
| Date: | |
|--------------|--|

Email form to: bord-uhb.caring4smiles@borders.scot.nhs.uk

Or post to: Priority Groups Team, Oral Health Promotion, Newstead, Melrose, TD6 9DA