Public Dental Service
Childsmile Referral

Name of Child/Young person (C/YP)			
CHI (DOB if CHI unknown)			
Address		**Postcode**	
Telephone Number(s)			
Email Address		**Details Crosschecked with EMIS/TRAK** Please Tick	
Parent /Guardian		**Relationship to C/YP**	
Siblings			
Parent/Carer consent gained for referral to be given to Childsmile Team:		**Yes/No**	
Reason for Referral Tick All That Apply	Was Not Brought to Dental Appointment(s) Oral Health Advice/Support BEDS/Emergency Attendance Follow Up Hospital e.g. GA Other:		
Risks to Dental Wellbeing Tick All That Apply	Significant pain/ sepsis /pathology/outstanding Treatment 2nd referral for same issues Repeat OOH(BEDS)/Emergency attendance Additional Care Needs Care Experienced/Child Protection/ Social Work Involvement		
Missed Dental Appt(s)	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 family.	Toothbrushing:		
	Nutrition:		
	Other:		
Any other relevant information			
Referrer		**Designation**	
Base Address			
Contact Tel/Email			
Date:			

Email form to: bord-uhb.childsmile@borders.scot.nhs.uk
Or post to: Childsmile, Oral Health Promotion, Newstead, Melrose, TD6 9DA