GAIN
GUIDELINES AND AUDIT IMPLEMENTATION NETWORK

FORM 2 – URGENT/NON-URGENT DENTAL REFERRAL*

*Please delete as appropriate

If the resident is registered with a dentist, it is important that this is the first point of contact.

NAME OF RESIDENT	DOB Health & Care Number
NEXT OF KIN	HOME TEL
RELATIONSHIP TO RESIDENT	MOBILE TEL
CARE HOME ADDRESS & TEL NUMBER	FAMILY DOCTOR ADDRESS & TEL NUMBER

*REASON FOR URGENT REFERRAL:

Dental pain	☐	Facial swelling	☐
Ulceration	☐	Gum boil/abscess	☐
Red/white patch	☐	other- please describe _____	

Does the resident have any of their own natural teeth? Y/N
Can the resident travel to the dental clinic? Y/N
If yes, who will accompany the resident? _____
If no, why is this? _____

PLEASE LIST THE RESIDENT'S MAIN HEALTH PROBLEMS, AND CURRENT MEDICATIONS (ATTACH COPY OF KARDEX)

PLEASE DESCRIBE ANY SPECIAL NEEDS RELEVANT TO THE RESIDENT, OR TICK ALL THAT APPLY E.G.

☐ Unable to consent/impaired understanding/communication difficulties		☐ PEG feeding/unsafe swallow
☐ Requires hoist to transfer	☐ Infection risk e.g. MRSA/C Difficile	☐ Challenging behaviour
☐ Other, please describe		

Signature of referrer _____ Job Title _____
Date _____/_____/_____

Send referral to family dentist/local dentist/dental access centre/community dentist (circle 1)