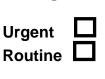
Cork University Dental School & Hospital: REFERRAL FORM

Please complete both sides and every section of this form and retain a copy for your records. Enclosures such as x-rays and periodontal charts should be sealed in an envelope marked with the patient's name and DOB and stapled to this form.

All referrals will undergo clinical triage. **Incomplete referrals may be returned.**

Referrals that do not comply with current CUDS&H patient referral protocols may be returned.





To: Consultant		From: Practice / Clinic (please write clearly)	
Dental Referral Management		Referring Dentist / Clinician	
Cork University Dental School & Hospital			
Wilton, Cork	Practice / Clinic Address:		
Tel: 021-490 1100			
Fax: 021- 434 5737 (Restorative Dept)			
Fax: 021- 490 1179 (Oral Surgery Dept		Postcode:	
		Tel:	
Email: dental@ucc.ie	Fax no:		
Date Referral Letter Received:	Email:		
(please write clearly or Hospital date stamp on receipt)		Dentist / Clinician Signature:	
	Principal Dental Surgeon Signature:		
PATIENT DETAILS		Patient's Address:	
Full Name:			
Parent / Guardian:			
Date of Birth:			
Daytime Tel:			
Mobile Tel:		Postcode	
Med Card No:Expiry Date:		Health Ins. Yes/No Specify:	
PATIENT'S MEDICAL PRACTITIONER		GP Practice Name & Address:	
GP Name:			
Tel:			
Fax:			
Email:		Postcode:	
Section A - Refer to Speciality Please tick relevant box(es).		Section B - Special Needs / Care Dentistry Please tick box(es) that are applicable to this referral.	
Dental Radiology		Mental Health	
Oral & Maxillofacial Surgery		Learning Disability	
Oral Medicine		Uncooperative	
Paediatric Dentistry (incl. child with special needs) Please complete section B		Hoist or bariatric facility	
Special Needs / Care Dentistry (adults) Please complete section B		Phobic Adult - ASA I or II	
Orthodontics (Currently only HSE referrals) Specialist form to be completed and attached		Special medical needs (medically compromised) - ASA II or III	
Restorative Dentistry			
Periodontics			
Prosthodontics			
Endodontics			

Patient Name:	DOB:	Referring GP/GDP:	

ADDITIONAL CLINICAL REFERRAL INFORMATION

Please complete all sections below. For those not applicable to the referral please put in **N/A**.

If any sections are blank the referral may be returned, delaying the patient's treatment.

If you do not have sufficient room please continue on a separate sheet quoting the patients name and DOB along with the relevant section letter that the additional information applies to in order to avoid any confusion.

Page 2

Section C: Clinical reason for referral – provisional diagnosis / treatment – description of problem / lesion : Restorative / Periodontal referrals should be accompanied with a BPE.
Section D Relevant medical history – current medication - ALLERGIES : Relevant family / social history:
PATIENTS PAST DENTAL REFERRAL HISTORY Previous Dental Referral No Yes If yes, please complete the following
Date of last dental referral: Where patient was treated : Reason for last referral:
PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT
Has the patient understood and consented to the referral? Yes No No
Section E: Any other relevant information or current treatment plan associated with this referral:
ATTACHMENTS - appropriate radiographs are essential.
Radiographs attached: tick if yes Periodontal charting attached: tick if yes
Signature of Referring Practitioner:
Print Name:
Please check that all sections are complete to prevent the possible return of this referral.
For CUDSH use only: Date Patient Registered:
Referral forwarded to Consultant: