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.

Urgent ☐
Routine ☐

To: Consultant

……..……..

Dental Referral Management

Cork University Dental School & Hospital

Wilton, Cork

Tel: 021- 490 1100

Fax: 021- 434 5737 (Restorative Dept)

Fax: 021- 490 1179 (Oral Surgery Dept

Email: dental@ucc.ie

Date Referral Letter Received: ……

(please write clearly or Hospital date stamp on receipt)

From: Practice / Clinic (please write clearly)

……

Referring Dentist / Clinician

……

Practice / Clinic Address:

……

……

Postcode: ……

Tel: ……

Fax no: ……

Email: …… …

Dentist / Clinician Signature: ……

Principal Dental Surgeon Signature: .....

PATIENT DETAILS

Full Name: ……

Parent / Guardian: ……

Date of Birth: ……

Daytime Tel: ……

Mobile Tel: ……

Med Card No: ……**Expiry Date:** ……

Patient's Address:

……

……

……

……

Postcode ……

Health Ins. Yes/No Specify:……

PATIENT'S MEDICAL PRACTITIONER

GP Name: ……

Tel: ……

Fax: ……

Email: ……

GP Practice Name & Address:

……

……

……

Postcode: …… ….

Section A - Refer to Speciality

Please tick relevant box(es).

- Dental Radiology ☐
- Oral & Maxillofacial Surgery ☐
- Oral Medicine ☐
- Paediatric Dentistry (incl. child with special needs) Please complete section B ☐
- Special Needs / Care Dentistry (adults) Please complete section B ☐
- Orthodontics (Currently only HSE referrals) Specialist form to be completed and attached ☐
- Restorative Dentistry ☐
- Periodontics ☐
- Prosthodontics ☐
- Endodontics ☐

Section B - Special Needs / Care Dentistry

Please tick box(es) that are applicable to this referral.

- Mental Health ☐
- Learning Disability ☐
- Uncooperative ☐
- Hoist or bariatric facility ☐
- Phobic Adult - ASA I or II ☐
- Special medical needs (medically compromised) - ASA II or III ☐

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.

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** ☐

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: …….. **Date:** ……

Print Name: …….

Please check that all sections are complete to prevent the possible return of this referral.

For CUDSH use only: Date Patient Registered: …….. CDS No:……
Referral forwarded to Consultant: …… Triage outcome: Urgent ☐ Soon ☐ Routine ☐