Western Health and Social Care Trust

Domiciliary Referral Form

Date of Referral: ……..……..…….

Referred by:

Name: …….

Address: ……..…….……

……...

Tel No: …… Position: ……

Patient Details:

Name: …….

DOB: …… H&C No: …….

Address:…….……

……

Next of Kin Name and Contact No: ……

……

Name of Contact Person e.g. Relative, Key Worker, Social Worker

……

Address: ……..……..……..

……

Daytime number: …….……

Name and address of GP: …….……....

……

Western Health and Social Care Trust

Does this patient have:

Natural teeth Dentures Both (please circle)

Reason for referral: .....

……

……

Urgent Non-Urgent (please circle)

Can the patient attend a dental clinic? Yes No

Does the patient attend hospital appointments? Yes No

If yes, does the patient use: Wheelchair taxi

Own transport

Ambulance transport

Know allergies: ……

Does the patient have:			Please give details
Communication difficulties	Yes	No	……..……..……
Dementia/ confusion	Yes	No	……..……..……
Mobility problems	Yes	No	……..……
Swallowing problems	Yes	No	……..……

<u>Please attach a completed medical history form and a photocopy of the patient's Kardex</u>