GENERAL REFERRAL TO CDS

Name of Patient: _____

Patient DOB: _____ Male/Female (please circle)

Address of Patient:

Interpreter Required: Y/N

Primary Language: _____

GMP: _____

Name of Parent/Guardian: :_____

Address:

Daytime Telephone:_____

Mobile Telephone:_____

Telephone number _____

Reason for Referral (*please tick all that apply***)**

Special Care adults/children (Physical/Learning Disabled) ☐

Require Domiciliary Care ☐

Children with Disproportionate Anxiety Behavioural Difficulties ☐

Medically Compromised (*unsuitable for treatment in general practice*) ☐

Mental Health (*known to community psychiatric team*) ☐

Medical History *(please attach medical history form)*

Treatment Requested

Radiographs: Please enclose any recent radiographs. These will be returned after treatment is completed

Signature Referring Dentist: _____ **Date**:_____

Print Name _____

Dentist Address:

Dentist Telephone Number: _____