**Community Dental Services
Information and Guidance for Referrers**

The Community Dental Services (“CDS”) provides dental treatment for children and adults who, for various reasons, cannot access the dental treatment they need in a General Dental Practice. The acceptance criteria has been detailed below.

We are a Paediatric & Special Care Dentistry Service who offer inhalational sedation and general anaesthetic facilities for children and adults but do not routinely offer an intravenous (IV) sedation service.

We also accept referrals for patients requiring domiciliary care, however this treatment is limited therefore domiciliary appointments will be considered on a case-by-case basis as per our acceptance criteria.

Accepted patients will be offered an initial assessment appointment and, if appropriate, a course of treatment. Eligibility for continuing care with the CDS will be re-assessed at each visit. Patients who no longer fall within the CDS remit will be discharged or referred to dental services appropriate to their needs where possible.

For all patients referred by a General Dental Practitioner’s, it is necessary that the patient receives all treatment they will accept in a general practice setting. The GDP should not discharge the patient from their care as they will be discharged from our service once treatment is completed.

Patients who fail to attend the initial appointment will be discharged back to the referrer in accordance with the CDS guidelines.

Patients who cancel will be rebooked in line with the current appointment availability and given one further appointment before discharge.

**Important**

* Patients will only be treated if they fall within the remit of the CDS (outlined on page 2)
* Patients using the service will be liable to pay for any NHS dental charges unless valid exemption provided
* Referrals can be from General Dental Practitioner, General Medical Practitioner or other Health or Social Care Professionals
* To be eligible to be seen within Leeds CDS, patients must be a resident in the Leeds Local Authority Area.

**How to refer**

Complete the referral form, which should be emailed to **cdstriage@nhs.net** from a secure e-mail (eg from “nhs.net” accounts).

Please complete all sections relevant to the referral, including relevant medical history and details of parent/legal guardian, and any other health or social care professionals involved in the patient’s care. This can be especially helpful when dealing with vulnerable patients. If the patient requires an interpreter or has specific mobility requirements with regards to needing a hoist or wheelchair tipper, please make sure this is also specified.

**Referrals will be rejected:**

* If incomplete or have insufficient information
* If sent for financial/economic reasons
* For common medical history problems that are manageable by a GDP eg Warfarinised patients

Patients whose only problem is finding an NHS Dentist should be advised to telephone **111** or access the **NHS** website. They will be able to give guidance as to how to access an NHS General Dental Practitioner. They may also be able to advise of practices with ground floor access.

**CDS Contact Details**

Telephone number: 0113 392 9875 E-mail cdstriage@nhs.net

**Referral Criteria for Leeds Community Dental Service**

Leeds CDS provides a Paediatric & Special Care Dentistry Service to children/adults from vulnerable groups, whose needs may not be accommodated in NHS general dental services, including:

* Moderate/severe and profound multiple learning disabilities;
* Moderate/severe physical and/or communication impairment;
* Moderate/severe chronic mental health conditions including dementia;
* Complex medical conditions;
* Severe dental anxiety or dental phobias (dental anxiety scale >19);
* Bariatric patients with a weight over 22 stones. we can accommodate a weight of up to 71 stones (454kg).
* Moderate or severe behavioural problems;
* Children in need and subject to a child protection plan with additional or complex needs;
* Looked after children with additional or complex needs;
* Clefts, abnormalities of dental development or dental trauma of increased complexity;
* Other complex dental conditions;
* Socially excluded people (case by case basis);
* People in secure units.

Community Dental Services Referral Form – NHS Confidential

**CDS Contact Details**

Telephone: 0113 392 9875

E-mail: cdstriage@nhs.net

Please refer to our acceptance criteria above prior to completing this form.

Please complete in full and email to our service as per the details provided.

**Date of Referral** (dd/mm/yy)**:**

|  |
| --- |
| **Patient’s details** |
|  |  |  |  |  |  |  |  |  |
| Title |  |  | Forename |  |  | Surname |  |  |
|  |
| Date of birth |  |  | NHS number |  |  | Gender: | Male [ ]  Female [ ]  |  |
|  |
| Address: |  |  |
|  |
|  |  |  | Postcode |  |  |
|  |
| Contact number |  |  | Alternative number |  |  |
|  |
| E-mail address |  |  |  NI number |  |  |
|  |
| Interpreter required | No [ ]  Yes [ ]  |  |  Language |  |  |
|  |
| Other communication aids | No [ ]  Yes [ ]  |  | Details |  |  |
|  |
| **Parent/Guardian/Carer/Next of Kin details** |
|  |  |  |
| Full name |  |  |
|  |
| Relationship to patient |  |  |
|  |
| Address |  |  |
|  |
| Telephone number |  |  | E-mail address |  |  |
|  |
| **Referrer’s details** |
|  |  |  |
| Name |  |  | Job tile |  |  |
|  |
| Work address |  |  |
|  |
| Work telephone number |  |  | E-mail address |  |  |
|  |
| Are you: | Dentist [ ]  | Doctor [ ]  | Health visitor [ ]  | Hospital (not LDI) [ ]  |
| Social worker [ ]  | Urgent Dental Care [ ]  | Other Health Care Professional [ ]  | Care Home [ ]  |
|  |

|  |
| --- |
| **Social Worker/Key Worker/Advocate details** |
|  |  |  |
| Full name |  |  |
|  |
| Relationship to patient |  |  |
|  |
| Address |  |  |
|  |
| Telephone number |  |  | E-mail address |  |  |
|  |
| Are you aware of a child protection plan for this patient | No [ ]  Yes [ ]  |  | Is the patient a “Child Looked After” | [ ]  |  |
|  |  |  |  |  |  |
| **GP details** |
|  |  |  |
| Full name |  |  |
|  |
| Address |  |  |
|  |
| Telephone number |  |  | E-mail address |  |  |
|  |
| Patient does not have a GP | [ ]  |  | Patient is on Leeds Care Record | [ ]  |  |
|  |  |  |  |  |  |
| **Pre school/School details** *(For safeguarding reasons)* |
|  |
| School Name |  |  |
|  |
| Address |  |  |
|  |
| Telephone number |  |  | E-mail address |  |  |
|  |
| **Consent** |
|  |  |  |  |  |
| Patient has capacity to consent | Yes [ ]  | No [ ]  | Not sure [ ]  |  |
|  |  |  |
| If the patient is under the age of 18, who has parental responsibility: |  |
|  |  |  |
| Name |  |  | Parent/Guardian/Social worker |  |  |
|  |  |  |
| Does the above named individual give consent for the examination, treatment and to the following (Questions 1 to 5) | Yes [ ]  No [ ]  |  |
|  |  |  |
| Has the patient given consent to: |  |
| 1. The Leeds Community Dental Services requesting a medical summary from their GP?
 | No [ ]  Yes [ ]  |  |
| 1. Access Leeds Care Record
 | No [ ]  Yes [ ]  |  |
| 1. Receive appointment reminders by text or e-mail
 | No [ ]  Yes [ ]  |  |
| 1. Share relevant information with other health care professionals
 | No [ ]  Yes [ ]  |  |
| 1. Use anonymised patient record for audit and service development purposes
 | No [ ]  Yes [ ]  |  |
|  |  |  |
| **Reason for Referral** *(please tick all that applies)* |
|  |  |  |  |  |  |
| Learning disability  |  [ ]  | Severe Mental Health Problems | [ ]  | Significantly medically compromised | [ ]  |
|  |  |  |  |
| Bariatric (*BMI over 40)* [ ]   | Phobic/severe anxiety [ ]  | Positive Behaviour Support Plan in place*(If yes, please attach to this referral)* | [ ]  |
|  |  |  |  |
| Mobilitywheelchair/hoist | [ ]  |  | Previous CDS patient (referred to you under flexible commissioning)  | [ ]  |
|  Other *(please specify)* [ ]  : |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **Medical history details** |
| List of main medical conditions: |
|  |
|  |
|  |
|  |
| List of current medication: |
|  |
|  |
|  |
| List of known allergies: |
|  |
|  |
|  |
| Mental health diagnosis: |
|  |
|  |
|  |
| Under the care of a Consultant: |
|  |
|  |
| **Clinical details of the referral** |
| Reason for referral / patient concern: |
|  |
|  |
|  |
|  |
|  |
|  |
| Please provide details of any attempts to treat the patient in a General Dental Practice setting. If no assessment or treatment has been attempted, please explain why not: |
|  |
|  |
|  |
|  |
|  |
|  |
| Have Xrays been taken? | Yes [ ]  No [ ]  | If yes: |
| If no why not: |  |  | Are these attached to the referral [ ]  |
|  |  | Date taken: |  |
|  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |
| ***Please answer the following questions:*** |
| Reason for the referral discussed and explained | No [ ]  Yes [ ]  |
| Previous dental referral sent | No [ ]  Yes [ ]  |
| Has the GP/Specialist/Social Worker been copied in  | No [ ]  Yes [ ]  |
| Has the patient agreed to attend appointments or contact to cancel as early as possible | No [ ]  Yes [ ]  |
| Has the patient been given preventative advice/treatment prior to the referral | No [ ]  Yes [ ]  |
| Is the patient aware they will need to pay for treatment or provide valid exemption | No [ ]  Yes [ ]  |
| Is the patient aware once the treatment is complete they will be discharged back to the General Dental Practitioner or signposted to 111 or find a NHS Dentist | No [ ]  Yes [ ]  |
|  |  |
| Please tick this box to confirm that you have not referred this patient to any other provider for their current problem | [ ]  |
|  |  |

**Using the secure e-mail send completed forms and attachments to** **cdstriage@nhs.net**