**PDS Special Care Hub – 0141 314 6669** [**gg-uhb.publicdentalspecialcare@nhs.net**](mailto:gg-uhb.publicdentalspecialcare@nhs.net)

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| **GDS Triage Referral Form** | |
|  | Date : Time : |
| Patient Name :  Male  Female |  |
| Patient Address  (inc postcode) : |  |
| Patient Contact Number : |  |
| Date of Birth : |  |
| CHI No (if known) : |  |
| Name of Referring Dentist : |  |
| Practice Address : |  |
| Dentist Contact Number : |  |
| Reason for Referral/Treatment Required:  (Brief outline of clinical picture) | Diagnosis and tooth:  Outcome : Extraction  Extirpation  Other  …………………………………. |
| Relevant PMH :  Is the patient over 28st (177kilos) YES  NO |  |
| Meds : |  |
| Allergies : |  |
| Has patient been given Advice/Analgesia/Antimicrobials ?  YES  NO | Give details and dates : |
| Are radiographs or photos available and attached ?  YES  NO | Give details and dates : |
| Is the patient in a high risk group for becoming seriously ill ?  (see SDCEP document) | YES  NO  Is the patient shielding YES  NO |
| COVID-19 screen | Does the patient or anyone they live with, have:  Cough  Fever  No symptoms  Loss of/change in sense of smell or taste |
| Escort : YES  NO | Does the escort have symptoms of COVID-19 ? YES  NO |
| Additional Notes : |  |
| **Section below for PDS use only** |  |
| Receiving Clinician : | Date : Time : |
| Has the patient to be appointed to clinic ? | YES  NO  If No : Prescription Issued  Other (give details) |
| If Yes ; | Allocated to :  Diagnosis and Tooth :  Treatment Provided : Extraction  Extirpation  Specialist Referral  Other (give details) |