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 ☐	
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) ☐	