

**Referrals will only be accepted on full completion of this form. Incomplete forms may be returned.**

**PLEASE COMPLETE BOTH SIDES IN CAPITAL LETTERS**

**Solihull Special Care Dental Service**

|  |
| --- |
| **Referral to Solihull Special Care Dental Service**(Patient with disabilities, medical conditions or dental phobia/behavioural problems at the severe end of the spectrum only.) |
| **Patient’s details**: (Male / Female) \*Surname: | **Referrers Name:****Profession:****Contact details:** |
| Forename: |
| Address: |
| Postcode: |
| Telephone No: |
| Date of Birth: | Telephone No: |
| NHS No |  |  |  |  |  |  |  |  |  |  | Date of Referral: |
| Name of parents/carer/guardian (and contact details if different to above): |
| Patients General Medical Practitioner Contact Details: ***(if not shown above)***Telephone No: |
| Is this referral (please tick): Routine Urgent If urgent why? |
| Has the patient agreed to this referral (please tick): Yes No |
| **REASON FOR REFERRAL**:  |

Page 1 of 2

Patients Name:

NHS No:

|  |
| --- |
| Medical condition(s): |
| Physical access (please tick):Unable to climb stairs Unable to transfer to dental chair Wheelchair userBedbound Domiciliary assessment required  |
| Communication problems: |
| Dental phobia/co-operation/behavioural problems: |
| **Please return form to** **Solihull Special Care Dental Service** **University Hospitals Birmingham NHS Foundation Trust** **Ground Floor, Netherwood Building****Solihull Hospital** **Lode Lane****Solihull, B91 2JL** **or electronically via** **uhb-tr.dentalreferral@nhs.net****If urgent please ring 0121 704 3211.** |
| For service use only:Date received: Clinician: Date of appointment: Clinic: |

Page 2 of 2

May 2022

For review: May 2023