Department of Restorative Dentistry
Morriston Hospital Heol Maes Eglwys Morriston Swansea SA6 6LN
☎Direct line/Rhif llinell union:🖷Fax/ffacs:01792 703101✉emailt:????????

Date:

Restorative Dentistry Referral pro-forma

Prior to referral please ensure that your referral is appropriate. **Inappropriate referrals will be returned.** Please also highlight to your patient that if they do not fulfill the guidelines on acceptance for treatment then they will be returned with appropriate advice and treatment plan. Please refer to Department Booklet.

Referring practitioner details

Patient Details

Name

Address

Dob

Contact No

Medical and Relevant Social history

(To include allergies / medication / pregnancy status/ other please specify)

(Please turn and complete overleaf)

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Patient history and reason for referral
(To include history of relevant treatment undertaken by referring practitioner)

Referring practitioner **CHECKLIST**

Please ensure you have included all relevant information and radiographs as referred to in the Department referral booklet.

Referring practitioner's signature

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Ymddiriedolaeth Prifysgol GIG
Abertawe Bro Morgannwg
University NHS Trust

Restorative Dentistry Referral pro-forma

Re:

We note your referral. Your patient has been placed on the new patient waiting list for:

Restorative Consultant Clinic Urgent ☐ Non –urgent ☐

Sedation assessment/ GA assessment ☐

Joint clinic with other specialty ☐

Passed to appropriate specialty ☐

The estimated current maximum waiting time for the above is _____

We note your referral and return it to you for the following additional information:

Patient referred for treatment not carried out in Hospital setting ☐
Incomplete medical history ☐
Incomplete clinical history and / or treatment history ☐
Lack of appropriate radiographs ☐
Endodontic treatment not complete ☐
No Basic Periodontal Examination (BPE) ☐
No history of periodontal therapy being undertaken ☐
No history of provision of removable prosthesis ☐
Lack of acclimatization attempts prior to sedation referral ☐
Necessity for general anesthesia not highlighted ☐
Confirmation that clinician has explained risks involved in GA / Sedation ☐
More appropriate to refer to Community Dental Service. ☐
Other (Please specify)

Please return information requested to

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