ABMUHB CDS

Date of Referral:

Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Dental Clinic:

Community Dental Service (CDS)
Referral Form

Please complete **ALL** sections of the form
Incomplete forms will be returned

Patient Details

Name: DOB:

Gender:

Address:

Postcode:

Tel No:

NHS No:

General Medical Practitioner

Name:

Address:

Postcode

Tel No:

Next of Kin/ Carer

Name:

Address:

Postcode:

Tel No:

Relationship to patient:

Referred by

Name:

Position/ relationship:

Address:

Postcode:

Tel No:

Medical History

Medical conditions/ allergies/ disabilities:

Medications:

Relevant Dental History
Please include information about the current dental treatment and any required treatment at CDS. If a General Dental Practitioner, please enclose any available radiographs.

Vulnerable Adult ☐ Vulnerable Child ☐

Indicators for a referral to CDS (please tick all that apply)

- ☐ Learning disabilities
- ☐ Mental health problems
- ☐ Physical disabilities: adapted wheelchair user ☐
- ☐ Complex medical history (please expand in medical history section)
- ☐ Disproportionate dental anxiety/ dental phobia
- ☐ Person in rehabilitation, secure unit, homeless ☐ ☐
- ☐ Inability to leave the home to seek care due to a form of disability
- ☐ Other, please state:

This box must be completed or the referral will be returned

Special Care requirements
e.g.

- ☐ Need for a hoist
- ☐ Language line

Has the patient been seen by the CDS before: Yes ☐ No ☐

Please return form to: Community Dental Service
Waiting List co-ordinator
Central Clinic
21 Orchard Street
Swansea
SA1 5AT
Telephone: 01792 517838