The Royal Dental Hospital of Melbourne

Dental Services Referral Form- Paediatric Dentistry

Date	/ /

Title:	Surname	Given name	Date of birth:

Street address	Suburb	Postcode
Name of Residential Facility (if applicable)		
Room:		

Phone - Home:		Mobile:		Work:	

Country of birth:	

Needs interpreter:	☐ Yes ☐ No	Language:	
Indigenous status:	☐ Neither Aboriginal nor Torres Strait Islander ☐ Aboriginal but not Torres Strait Islander ☐ Torres Strait Islander but not Aboriginal ☐ Both Aboriginal and Torres Strait Islander	☐ Not Stated	

Concession Card type:	☐ Pensioner Concession Card ☐ Health Care Card		
Concession Card No:		Expiry date:	

For Under 18 patients:

Parent/Guardian name(s):			
Relationship to patient:		Phone:	
School:			

For patients unable to provide self-consent:

Person Responsible name:			
Relationship to patient:		Phone:	
Address:			

Ability to attend appointments at short notice if available due to vacancies:		
☐ Within 24 hours	☐ Within 1 week	☐ No, require more notice

Once complete please return to:
Patient Services Centre The Royal Dental Hospital of Melbourne GPO Box 1273L Melbourne 3001

Paediatric Dentistry: For clinical criteria, exclusions, and patient information – Click here

Reason for referral:	**Treatment urgency**
☐ Examination and treatment ☐ Opinion only ☐ from information provided ☐ from examination of patient	☐ Urgency 1: Suspected malignancy, trauma, medical priority, patients to be seen the same day ☐ Urgency 2: Patient experiencing pain ☐ Urgency 3: Patient not experiencing pain

Are you referring this patient to more than one RDHM Clinic?

☐ No
☐ Yes – please specify the other RDHM clinic(s)

☐ Domiciliary Services	☐ Endodontics	☐ Implant
☐ Oral Medicine – Mucosal	☐ Oral Medicine - Facial Pain & TMD	☐ Oral & Maxillofacial Surgery
☐ Orthodontics	☐ Paediatric Dentistry	☐ Periodontics
☐ Prosthodontics - Fixed	☐ Prosthodontics – Removable	☐ Special Needs

Details for the referral:

Patient's / Person Responsible's main concern / dental needs (in their own words):

Briefly describe how the service requested fits in your overall treatment plan.

Summary of medical history: (please attach patient's current full history)

Notable issues	**Summary information**				**Details attached**
Physical or sensory impairment	☐ Sight	☐ Hearing	☐ Physical	☐ None known	☐
Intellectual impairment	☐ Learning	☐ Behaviour	☐ Communication	☐ None known	☐
Falls Risk / Pressure Ulcers	☐ Falls Risk	☐ Pressure Injuries		☐ None known	☐
Medications	☐ Prescribed	☐ Self administered		☐ None known	☐
Allergies / ADR	☐ Allergy	☐ Adverse Drug Reaction		☐ None known	☐
Other significant risks	☐ Yes	☐ No		☐ None known	☐

Requirements checklist

Additional information required;	**Current OPG less than 12 months old. We acknowledge not all small children or disabled patients can cope with obtaining an OPG but this should be routinely attempted prior to referral.** ☐ sent ☐ attempted but unable to obtain **Bitewing / Periapical radiographs** ☐ sent ☐ attempted but unable to obtain **Dental charting indicating any teeth requiring extraction** ☐ sent ☐ attempted but unable to obtain **Accurate medical history** ☐ sent **Detailed clinical history relating to the presenting complaint e.g. presence of pain, swelling, nocturnal pain, recurrent courses of antibiotics** ☐ sent **For patients where a general anaesthetic has been indicated**: **A completed General Anaesthetic Patient Health Questionnaire**. This can be found at https://extranet.dhsv.org.au/prgm-mgmt/rdhm-specialist ☐ sent **Clinical notes detailing more than two attempts at treatment by different operators under local anaesthetic.** Junior operators should seek assistance from more senior operators prior to referring patients. ☐ included in details section. **A definitive treatment plan.** Should this information not be included, the child will be referred to a general clinic where care will be provided by an Oral Health Therapist. Should treatment not be possible in the general clinic, they will be referred on to the Day Surgery Unit with radiographs and a treatment plan. This will be discussed with the family. Referring clinicians should make families aware of this arrangement in cases where appropriate information cannot be obtained. ☐ sent ☐ attempted but unable to obtain

Screening clinician's notes (RDHM use only):

Referring Clinician details:	**Phone:**
☐ Or completed on behalf of	
Please record provider type ☐ Dentist ☐ Oral Health Therpaist ☐ Dental Therpaist ☐ Dental Hygienist ☐ Other	
Clinic mailing address:	

Criteria Paediatric Dentistry

Appropriate patients	This service is for children and adolescents up to 15-16 years of age dependent on their development, and manages complex preventive and therapeutic dental problems. Care may be offered within two different streams of Paediatric Dentistry clinics dependant on the reason for referral. For example, General anaesthetic management of dental problems may be required.
Clinical criteria please tick criteria applicable to this patient	**Specialist Paediatric Dentistry** ☐ Complex dental pathology requiring specialist management (cysts, MIH) ☐ Special needs (intellectual, physical and sensory disabilities) ☐ Syndromes and other genetic disorders including amelogenesis imperfecta and dentinogenisis imperfecta) ☐ Medically compromised conditions such as Haemolytic disorders (e.g. Haemophilia, leukaemia, thrombocytopaenia etc.) ☐ Dental anomalies (supernumerary teeth, dilaceration, odontomes, missing teeth, ankylosed teeth) ☐ Behaviour management requiring relative analgesia ☐ Interceptive orthodontics, including management of conditions such as dehiscence, space maintenance, anterior and posterior cross bites, ectopic eruptions or non-eruption, habits, etc ☐ Early childhood caries that require complex surgical restoration procedures **General Paediatric Dentistry** ☐ Behavioural difficluties that may require management under general anaesthesia More than two attempts by different clinicians should be made to treat the patient under local anaesthesia before referring a child for a general anaesthetic.
Process for emergency referrals	☐ The referring clinician is to contact RDHM Patient Services on (03) 9341 1000 and ascertain the ability of the clinic to coordinate care on the day. ☐ Patients with acute symptoms should clearly mark this Dental Services Referral Form as urgent, indicating reasons for urgent attention. ☐ The patient must be provided with this completed Dental Services Referral Form and any available radiographs and directed to proceed to the main hospital reception after an appointment has been organised. Due to demand, it may not be possible to provide the care proposed for a particular patient on the same day. This particularly applies to patients requiring general anaesthesia. However, patients with potential serious infections (e.g. spreading cellulitis, submandibular abscess) will be seen on the same day. ☐ Prior phone notification is essential.
Exclusions	If a general anaesthetic is required, patients with Type 1 daibetes, blood dyscrasias or bleeding disorders or severe respiratory disorders should be referred directly to the Department of Dentistry at the Royal Children's Hospital.
Consultation please ensure your patient understands the following;	Patients meeting the referral criteria will be offered a screening consultation to assess treatment requirements. Where treatment under General Anaesthesia has been indicated without the provision of a definitive treatment plan, the child will be referred to an Oral Health Therapist to attempt treatment under local anaesthesia in the first instance. Patients assessed as needing procedures under General Anaesthesia will be placed on the appropriate waiting list. Waiting times are generally shorter for procedures that can be performed under local anaesthesia
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