dental health
services victoria
oral health for better health

Integrated Special Needs Dentistry Unit
Dental Health Services Victoria
720 Swanston Street, Carlton Vic 3053
Tel: (03) 9341 1000 **Fax:** (03) 9341 1214

Special Needs Dentistry
(school based service)

Application Form for Dental Examination

Patient Details

Surname: …… Given Name/s: ……

Female ☐ Male ☐ Date of Birth _____/_____/_____

Address: ……Postcode:……

Telephone number: …… Mobile:……

Child's country of birth: ……Mother's country of birth:…… ……..

Language(s) spoken at home…… Interpreter required? Yes / No

Are you of Aboriginal or Torres Strait Islander origin? Yes / No

Name of child's school……

Consent Details

Consent is given for (insert patient name) …….. .. to receive a dental examination to be provided by a dentist or dental therapist from the Special Needs Dentistry Unit of Dental Health Services Victoria (DHSV).

By providing this consent you have given permission for a dental examination to take place. Following the examination you will be contacted to discuss clinical findings and give consent for any agreed treatment.

Name: …… ……Signature: ……..

Address:……

… Relationship to patient: ……Date: ____/____/____

Current Dental Needs

I would like my child to have a dental check up only	**yes / no**	I only want emergency treatment for my child's main dental problem *(give details)* …… ……	**yes / no**
I have particular concerns about my child's dental health *(give details)* …… ……	**yes / no**	I want all my child's dental problems treated (a complete course of dental care)	**yes / no**

Dental History

Has your child had a dental examination before? *(give details: when / where)* …… ……	**yes / no**	Has your child attended The Royal Dental Hospital of Melbourne before? *(give details: when / why)* …… ……	**yes / no**
Has your child ever had a general anaesthetic for dental treatment?	**yes / no**	Has your child ever had problems following dental treatment? *(give details)* …… ……	**yes / no**

Please turn over

dental health
services victoria
oral health for better health

Integrated Special Needs Dentistry Unit
Dental Health Services Victoria
720 Swanston Street, Carlton Vic 3053
Tel: (03) 9341 1000 **Fax:** (03) 9341 1214

Medical Questionnaire

Patient's Surname …… **Given Name** ……

Current Medication

Please specify current prescription and over the counter medications: ……

……

……

……

……

Drug allergies: yes / no *(If yes please describe)* ……

……

Medical History

As some medical conditions may affect dental care, please complete the following details.
Has your child ever had any of the following medical conditions? Circle yes or no for each condition and if yes, give details.

yes	no	Heart disease/ heart murmur	Details
yes	no	Rheumatic fever	
yes	no	Epilepsy	
yes	no	Bleeding requiring medical treatment	
yes	no	Blood disorders	
yes	no	Kidney disease	
yes	no	Asthma or other respiratory diseases	
yes	no	Diabetes	
yes	no	Liver disease (including hepatitis)	
yes	no	Allergic or adverse reaction to medicines/ other substances (including latex)?	
yes	no	Has your child ever been a patient in hospital?	
yes	no	Does your child have a particular diagnosis	

Is there anything else regarding your child that you feel is relevant to the provision of dental treatment? (For example, swallowing problems, physical problems, behavioural problems)

……

……

……

……

Medical Practitioner Details

Medical Practitioner's name: . ……

Address: ……

Telephone Number: ……

Signature of Parent/ Guardian: ……. Date: ……../……../……

Thank you for completing this questionnaire. If you have any questions, please contact us on 9341 1000.