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|  | **Dental Services Referral Form- PERIODONTIC CLINIC****Date:**       |

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| **DRN/ UR**  | **Title:**  | **Surname** | **Given name** | **Date of birth:** |
|       |       |       |       |       |

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

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| **Phone - Home:** |       | **Mobile:** |       | **Work:** |       |

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| --- | --- | --- | --- |
| **Country of birth:** |       | **Cultural background:** |       |

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| **Needs interpreter:**  |  **[ ]  Yes [ ]  No** | **Language:** |       |
| **Indigenous status:** |      :  |
| **Priority access:** |  |

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| --- | --- |
| **Concession Card type:** |  |
| **Concession Card No:** |       | **Expiry date:** |       |
| **Medicare Card:** |  Patient no.       |
| **Medicare Card No:** |       | **Expiry date:** |       |

**For Under 18 patients:**

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

**For patients unable to provide self-consent:**

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

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| **PERIODONTICS UNIT – OVERVIEW**  |
| The Periodontics Unit provides diagnosis, prevention and treatment of **moderate to severe** periodontitis. |
| **COMPLEX PROSTHODONTIC AND DENTAL IMPLANT THERAPY** |
| A limited number of cases may be considered for the provision of complex prosthodontic and dental implant treatment through the Melbourne Dental School (MDS) Teaching Programs via patients already accepted by RDHM Prosthodontic Unit. Please refer to pages 2 & 3 of the Referral for Specialist Dental Care Procedure.  |
| **MAINTENANCE OF DENTAL IMPLANTS**   |
| Only cases where the implant therapy was provided at the RDHM will be accepted for maintenance in the specialist or postgraduate teaching clinics.  |
| **SPECIALIST-IN-TRAINING TEACHING CASES – Consideration of Complex Cases**   |
| RDHM is a teaching hospital and therefore a limited number of complex cases **may** be accepted for postgraduate training purposes. Training cases should align with the value-based health care principles in a public dentistry setting.  **Note:** There is no direct referral process to Postgraduate teaching programs. Case selection and acceptance will be considered separately for specialist-in-training. **[ ]** This patient ***does not wish*** to be managed by Specialists-in-training. Time to treatment may be delayed if opted not to be seen by Specialists-in-training. |
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| **CLINICAL CRITERIA FOR REFERRAL** |
| **[ ]** Periodontitis Classification Stage III or IV* pocket probing depth of ≥ 6mm - Localised or Generalised
* clinical attachment loss of ≥ 5mm **and** furcation involvement
* drifting or mobile permanent teeth

**[ ]** Clinical Evidence of acute or rapidly changing periodontal symptoms* any rapid changes in gingival contour and texture or pocket depth
* multiple/periodontal abscess formation

**[ ]** Recession defects with clinical evidence of deterioration (charting over a 6-month period), or a major aesthetic concern**[ ]** Periodontal disease in individuals with significant medical history (eg. Severely immunocompromised patient, IV bisphosphonates, severe blood dyscrasia)**AND** the following mandatory criterion for **all patients:****[ ]** Demonstrated ability to maintain oral hygiene with a plaque score < 15% (shown in a minimum of 2 O'Leary plaque index scores) |
| **EXCLUSION CRITERIA** |
| * Plaque index >15%. Patients who cannot maintain a high standard of plaque control will not progress beyond initial phase therapy and may be considered for a referral to the Dental Teaching Clinic (DTC)
* Management and maintenance of any **externally placed dental implants will not be accepted**
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| **PREREQUISITES FOR REFERRAL** |
| **[ ]** Management of general dental care and any ongoing care required/requested during Specialist management including fabrication of dentures**[ ]** Periodontal charting (including probing depths, mobility, bleeding / discharge), and two O’Leary plaque index scores to demonstrated improvement in plaque scores.**[ ]** A [ ] diagnostic quality OPG radiograph less than 12 months old**[ ]** Bitewing and periapical views of diagnostic quality as appropriate**[ ]** Clinical history to include details of symptoms and any previous treatment including use of antibiotics**[ ]** Treatment history (dates of initial therapy, review appointment findings and charting).**[ ]** Accurate medical history |

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| **REASON FOR REFERRAL** |
| [ ]  Examination and treatment [ ]  Opinion only [ ]  Telehealth |
| **Referral Urgency** |
| Referral indication of Urgency for Specialist Care (see Appendix to Referral to the Royal Dental Hospital of Melbourne Procedure) [ ]  Urgency 1 [ ]  Urgency 2 [ ]  Urgency 3  |
|  **Patient’s / Person Responsible main concern / dental needs (in their own words):** |
|       |
| **Details for the referral:** |
|       |
| **Provisional or Definitive Diagnosis** |
|       |
| **Briefly describe how the service requested fits in your overall treatment plan.** |
|       |

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| **Summary of medical history:**  |
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| **Notable issues** | **Summary information** | **Details attached** |
| Physical or sensory impairment | [ ]  Sight | [ ]  Hearing | [ ]  Physical | [ ]  Nil known | [ ]  |
| Intellectual impairment | [ ]  Learning | [ ]  Behaviour | [ ]  Communication | [ ]  Nil known | [ ]  |
| Falls Risk / Pressure Ulcers | [ ]  Falls Risk | [ ]  Pressure Injuries | [ ]  Nil known | [ ]  |
| Medications | [ ]  Prescribed | [ ]  Self-administered | [ ]  Nil known | [ ]  |
| Allergies / ADR | [ ]  Allergy | [ ]  Adverse Drug Reaction | [ ]  Nil known | [ ]  |
| Other significant risks  | [ ]  Yes | [ ]  No | [ ]  Nil known | [ ]  |
| *Details of other risks:* |

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| **Does this patient require support services such as a Social Worker?** |
| [ ]  No[ ]  Yes  | If yes, please provide a brief overview of support services required:      |

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| **Referring Clinician details:** | **Phone:** | **Clinical Supervisor** |
|      [ ]  Or completed on behalf of       |       | Approval provided by:      |
|   | For Students:  |
| ***Community Dental Clinic referring:***  |       |
| ***Community Dental Clinic mailing address:***  |                 |
| ***Referring Clinician email:***  |       |