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|  | **Dental Services Referral Form- Oral Medicine-MUCOSAL 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:       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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:** |  |

|  |  |
| --- | --- |
| **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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| **ORAL MEDICINE UNIT - OVERVIEW** |
| The Oral Medicine Unit is responsible for the diagnosis, prevention and predominantly non-surgical management of oral mucosal disease, chronic orofacial pain and the oral manifestations of systemic disease. This includes oral dermatoses, oral malignancies, temporomandibular disorders, oral dysaesthesias and pain of neuropathic origin. Oral Medicine may accept referrals from dental practitioners ***as well as medical and other health practitioners***.  |
| **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. |
| **REFERRAL CRITERIA FOR URGENT MANAGEMENT ORAL MEDICINE PATIENT** |
| **[ ]** Conditions that may require urgent referral management include: **Suspected malignancy** |
| **URGENT MANAGEMENT ORAL MEDICINE PATIENT REFERRALS** |
| The referring practitioner is to contact RDHM Oral Medicine Unit on **(03) 9341 1120** to ensure appropriateness of referral & ascertain the ability of the clinic to coordinate care on the day.   Conditions that may require urgent referral management include: (Urgency 1)  **[ ]** Suspected malignancy **[ ]** Patients suspected to have Trigeminal neuralgia The patient must be provided with a completed Oral Mucosal Referral or Orofacial Pain 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. **Prior phone notification and confirmation of the receipt of the referral is essential.** |
| **REFERRAL CRITERIA – MUCOSAL CLINIC**  |
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| **[ ]** Non-healing ulcer  **[ ]** Red patches **[ ]** Recurrent oral ulceration  **[ ]** Pigmented lesions**[ ]** Persistent ulceration  **[ ]** Gingival swellings **[ ]** Blistering conditions  **[ ]** Xerostomia**[ ]** White patches    |

 |
| **PREREQUISITES FOR ORAL MUCOSAL REFERRAL** |
| **[ ]** Diagnostic-quality clinical photographs are preferable to avoid delays **[ ]** Radiographs for bony lesions **[ ]** Results of haematological or other pathology investigations. **[ ]** Radiographs for gingival lesions with description of special test done (gingival probing & CO2 etc)**[ ]** Complete the attached Oral Mucosal Checklist – Oral Mucosal Referrals |

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|  **REASON FOR REFERRAL - Mucosal Clinic** |
|  **[ ]** Examination and treatment            **[ ]** Opinion only             **[ ]** Information provided by 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 / Responsible person’s 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:      |
|  [ ]  Medical Practitioner (see bottom three items)  | For Students:  |
| ***Community Dental Clinic referring:*** |       |
| ***Community Dental Clinic mailing address:*** |                 |
| ***Referring Clinician email:*** |       |
| ***Medical Practice Clinic referring:*** |       |
| ***Medical Practice Clinic mailing address:*** |                 |
| ***Medical Practice Clinic email address:*** |       |

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| **Ongoing care required by referring clinician** |
| By submitting this referral, I on behalf of the referring clinic, agree to:[ ]  Ensure that appropriate symptomatic relief is provided to the patients as required [ ]  Overall general care to this patient while on the waiting list |

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| **ORAL MEDICINE CHECKLIST – Mucosal Referral Details** |
| Please provide as much detail as possible. If insufficient detail is provided, there may be a delay in the processing of this referral. |

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| **Reason for referral:** |
| [ ]  White patch [ ]  Red patch | [ ]  Red/white patch[ ]  Swelling / lump | [ ]  Ulcer |
| [ ]  Pigmented lesion. *Specify colour:*        | [ ]  Other: *describe*        |
| **Smoking** | **Alcohol consumption** | **Alcohol containing mouthwash** | **Paan use (Betel quid)** |
| [ ]  Never[ ]  Occasional[ ]  Past (# per day:     ) For       yearsQuit Date:       | [ ]  Never[ ]  Occasional[ ]  Past:For       yearsQuit Date:       | [ ]  Never[ ]  Occasional[ ]  Past:For       yearsQuit Date:       | [ ]  Never[ ]  Occasional[ ]  PastFor       yearsQuit Date:       |
| [ ]  **Current**[ ]  Rolled[ ]  Packaged# per day:      For       years | [ ]  **Current**[ ]  Weekly:Amount per week:     Alcohol type:      [ ]  Daily:      glasses per dayAlcohol type:        | [ ]  **Current**[ ]  Weekly:Amount per week:      [ ]  Daily:  # per day:      Mouthwash type:  | [ ]  **Current**# per day:      For       years[ ]  Current# per day:      For       years |
| **History of Presenting Complaint:** |
| Who noticed this problem? | [ ]  Patient [ ]  Clinician |
| Duration (if known) |        |
| Cause (if known) |       |
| Symptomatic: | [ ]  No [ ]  Yes (please fill out section below) |
| Aggravating factors: |       |
| Alleviating factors: |       |
| Are there any skin or other mucosal lesions present? |       |
| Any previous investigations / treatment? |       |
| **If you suspect the lesion is traumatic in origin with a known cause, please manage and review the patient in two weeks. If the lesion has not resolved, then refer. If the lesion meets priority 1 urgent referral criteria, please contact RDHM on (03) 9341 1120 to speak to the Oral Medicine Clinic directly, to coordinate care and ascertain the ability of the clinic to provide care in a timely manner.** |

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| **Examination:** |
| Lymphadenopathy (submandibular/cervical): [ ]  [ ]  Yes [ ]  [ ]  NoPlease provide an accurate description of the lesion: * Site(s)
* Size
* Borders
* Texture
* Feeling on palpation (soft, fibrotic, indurated, bony)
 |
| **Please attach a photograph of the lesion. If you have any queries, please contact the Oral Medicine Clinic on 9341 1120** |