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|  | **Dental Services Referral Form- ENDODONTIC UNIT****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:** |  |

|  |  |
| --- | --- |
| **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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| **ENDODONTICS UNIT – OVERVIEW**  |
| The Endodontic Unit provides specialist Endodontic care for a tooth that has been considered to be suitable to be maintained, has a favourable restorative and periodontal prognosis and is of high strategic value, within the context of a whole of dentition treatment plan, which has been accepted and approved by the patient. |
| **CONSIDERATIONS BEFORE REFERRAL** |
| * the scope for endodontic treatment within the clinic has been fully explored, including in-house referral to senior practitioner for appropriate management
* the tooth has all caries removed, is restorable, and has adequate coronal tooth structure and good periodontal prognosis
* the tooth can be isolated with a dental dam.
* the interim restoration of the tooth is durable, overlaid and of a nature that precludes coronal leakage.
* a restorative treatment plan is provided.
* any emergency care will be managed by the referring clinic whilst the patient is waiting for RDHM specialist care.
 |
| **Clinical Criteria for Referral** |
| **[ ]** Tooth pulp damaged and infected due to caries, disease or trauma which is beyond the scope of a general dentist. **[ ]** Endodontic Retreatment **[ ]** Curved and missed canals **[ ]** Fractured instruments in canals**[ ]** Open apices**[ ]** A referral may be accepted in cases where a patient is on bone-modulation medication to avoid tooth extraction and medical advice has indicated so. (coronal part of root sealed and submerged)  |
| **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. |
| **EXCLUSIONS** |
| * Second and third molars will not be accepted unless they are strategic teeth (bridge abutment or only remaining functional molar in that quadrant) **with good prognosis** or for selected teaching cases.
 |
| **Prerequisites for Referral** |
| **[ ]** Complete all general dental care prior to the referral with statement of confirmation.**[ ]** Provide evidence that oral disease (dental caries/periodontal disease) has been stabilised and is being adequately maintained by the patient.**[ ]** Submission of diagnostic quality preoperative periapical radiographs and bite-wing radiographs.[ ]  An individual dentist with whom the Endodontist can speak to, and who is responsible for the overall management of the patient, including placement of a final restoration |

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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:***  |       |