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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:** |  | | |

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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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| **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):** |
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| **Details for the referral:** |
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| **Provisional or Definitive Diagnosis** |
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| **Briefly describe how the service requested fits in your overall treatment plan.** |
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| **Summary of medical history:** |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **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:*** |  | | |