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

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| **UR / DRN** | **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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| **Ability to attend appointments at short notice if available due to vacancies** |
| **Within 24 hours** | **Within 1 week** | **No, require more notice** |

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| **DENTAL TEACHING CLINIC - OVERVIEW** |
| The Dental Teaching Clinic (DTC) provides holistic treatment and management of oral health disease by the Melbourne Dental School and RMIT (Royal Melbourne Institute of Technology) students. DTC accepts all eligible patients who are entitled to care in the public system.Students have general dentistry sessions as well as sessions supervised by specialists and/or specialist postgraduate students such as endodontics, prosthodontics, etc.Following completion of care and one recall, patients will be discharged back to their local community clinic.Patients who fail to attend 3 appointments or are unable to be contacted after 14 days will have their subsequent appointment slots given to other patients and their course of care will be closed. |
| **CONSENT**  |
| Student care, although free, will take longer than treatment with qualified clinicians and patients may frequently have appointments where not very much clinical work may seem to be done. For these reasons, patients must fit the following criteria **[ ]**  Consent to be seen by supervised students.**[ ]** Understand/accept that completing examination may take more than one appointment.**[ ]** Able to tolerate long appointments (up to 3 hours).**[ ]**  Understand/accept that they may be seen by multiple students during their course of care.**[ ]** For continuity of care, patients must have flexibility around the days they are available for  treatment and understanding that university semester breaks may impact appointments.**[ ]**  Able to come into RDHM for regular appointments. (Usually weekly or fortnightly). **[ ]** The patient/carer understands that fees may apply if additional treatment is required in the non-teaching  clinic. These fees will be discussed with the patient in the specialist area before commencing treatment. |
| **ASSESSMENT CLINIC**  |
| * The first appointment is for an assessment, disease control and health education. The supervisors will assess the options for student treatment.
* Patients who decline treatment or are assessed as inappropriate for the teaching clinic will be directed back to their referring and/or local community clinic.
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| **CLINICAL CRITERIA FOR REFERRAL – BY TREATMENT TYPE** |
| **General care** | [ ]  Patient requires simple restorative, periodontal and preventative care[ ]  Patient requires more complex restorations of posterior teeth |
| **Paediatric Dentistry** | **[ ]** Patients up to 18 years of age (high demand for under 12 years)**[ ]** Patient able to be treated in a dental chair**[ ]** Parents must be available to attend each appointment with the child**[ ]** Indication of interpreter in patient details section if required |
| **Endodontics** | **[ ]** Tooth is restorable with a good prognosis**[ ]** Tooth can be easily isolated with a rubber dam**[ ]** Patient requires simple endodontic treatment- single canal anterior teeth or premolars**[ ]** Patient requires treatment for simple multi-rooted teeth- maxillary premolars and first molars. Second and third molars will not be accepted unless they are strategic teeth (bridge abutment, only remaining second molar in that quadrant).**[ ]** Patient requires simple retreatmentNB: Immature teeth, teeth with sever pulp calcification, extreme curvatures or inclination or resorption are not suitable for the student clinics. |
| **Periodontics** | [ ]  Patient requires periodontal treatment (including maintenance treatment) for localised area[ ]  Patient requires periodontal treatment (including maintenance treatment) as part of a general treatment plan[ ]  Patient requires treatment for simple periodontal disease (sub-gingival calculus, up to 5mm pockets, with no furcation involvement)[ ]  Patient requires treatment for complex periodontal disease not requiring specialist care (periodontal pockets greater than 5mm; can include some with furcation involvement) |
| **Removable Prosthodontics** | **[ ]** All general care should be provided by the referring clinic prior to the patient being referred **[ ]** Minimal loss of vertical dimension and normal occlusal plane. NB: Excessive skeletal class II and class III relationships and compromised occlusal planes should be avoided. |
| **Fixed Prosthodontics** | **[ ]** All general care should be provided by the referring clinic prior to the patient being referrer**[ ]** Healthy periodontium, excellent oral hygiene, caries free dentition**[ ]** Patients requires anterior and/or posterior single crowns without other restorative work**[ ]** If non-vital, endodontics completed with good obturation, otherwise refer to endodontics |
| **Special Needs** | **[ ]** Patient requires simple restorative, periodontal and preventative care**[ ]** Patient has enough compliance to withstand long appointments with students**[ ]** Patient is able to come for multiple appointments |
| **EXCLUSION CRITERIA** |
| **[ ]** Severe back, neck and temporomandibular joint pain**[ ]** Complex psychosocial circumstances e.g. Severedental phobia, aggressive behaviour patterns**[ ]** A history of complaints regarding dental services**[ ]** Complex clinical cases, for example tooth wear, endodontic retreatment or full mouth rehab**[ ]** Unable to tolerate long appointments**[ ]** Prefer not to see students |

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| **PREREQUISITES FOR REFERRAL** |
| **[ ]** Current medical history (less than 6 months old)**[ ]** Current OPG radiograph (less than 12 months old)**[ ]** Consent for student treatment |

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|  **Treatment Required** |
| Please tick all that apply: **[ ]** General Care**[ ]** Periodontics**[ ]** Fixed Prosthodontics**[ ]** Endodontics (straightforward)**[ ]** Endodontics (molar) **[ ]** Special Needs Care**[ ]** Paediatric dentistry (<18 years – no waitlist applies) | **[ ]** Dentures:**[ ]** F/F**[ ]** F/P **[ ]** P/F**[ ]** F/-**[ ]** -/F**[ ]** P/P**[ ]** -/P**[ ]** P/- |  |
|  **Patient’s / Responsible person’s main concern / dental needs (in their own words):**   |
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|  **Details for the referral:** |
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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:*** |       |

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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 |