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|  | **Dental Services Referral Form – PAEDIATRIC DENTISTRY**  **Date:** |

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| **Agency DRN/UR** | **Title:** | **Surname** | **Given name** | **Date of birth:** |
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| **Street address** | **Suburb** | **Postcode** |
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| **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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| **PAEDIATRIC DENTISTRY UNIT - OVERVIEW** |
| This service is for children and adolescents up to **18** years of age dependent on their development and manages complex preventative and therapeutic dental problems. |
| **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. |
| **EMERGENCY PAEDIATRIC PATIENT REFERRALS** |
| * For **urgency 1 patients who need to be seen on the same day,** the referring practitioner is to contact RDHM Paediatric Dentistry Unit on **0487214283** and ascertain the ability of the clinic to coordinate care on the same day. The patient is to be provided with this Paediatric Dentistry Referral Form, 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. Patients with potentially serious infections (eg spreading cellulitis, systemic signs and symptoms) will be seen on the same day. * ***For emergency care of significant complex trauma please refer to RDHM emergency department or The Royal Children’s Hospital 9345 5344. (After hours Registrar 9345 5522 through Hospital Switchboard)* Prior phone notification and confirmation of the receipt of the referral is essential.** * For **urgency 1 patients who require urgent appointment but not same day and urgency 2 patients,** the Paediatric Dentistry Referral should be clearly marked as URGENT indicating the reasons for urgent attention. If insufficient clinical information is recorded (eg detailed pain history), this will lead to delayed assessment. |
| **CLINICAL CRITERIA FOR REFERRAL** |
| ***Please tick criteria applicable to this patient:***    Complex dental pathology requiring specialist management (cysts, enamel hypomineralisation or hypoplasia)    Special needs (intellectual, physical and sensory disabilities)    Syndromes and other genetic disorders including amelogenesis imperfecta and dentinogenisis imperfecta    Medically compromised patients.  Note: Patients who require support of a tertiary hospital such as patients with Type 1 diabetes, blood dyscrasias or bleeding disorders, severe congenital heart disease or severe respiratory disorders should be referred directly to the Department of Dentistry at the Royal Children’s Hospital.    Dental anomalies (supernumerary teeth, dilaceration, odontomes, missing teeth, ankylosed teeth, primary failure of eruption)    Follow up care for complex dental trauma.    Patients requiring advanced behaviour management requiring relative analgesia or general anaesthetic.  **The decision for treatment under sedation or general anaesthetic will be made by**  **RDHM specialist and parent at the consultation visit.**  Caries and early childhood caries that require complex surgical restoration procedures. For all caries referrals it is a requirement that oral health education is provided by the referring clinic, a minimum of two sessions is expected but more may be required to support behaviour change.  For children without special needs or significant medical conditions it is expected that minimal intervention dentistry options be attempted before referral, unless teeth are symptomatic or clinical/radiographic evidence of pulp/periapical infection  ***Patients meeting the referral criteria will be offered a consultation to assess treatment requirements*** |

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| **EXCLUSION CRITERIA** |
| If a general anaesthetic is required, patients with the following conditions should be referred directly to the Department of Dentistry at The Royal Children's Hospital Melbourne (RCH): <https://www.rch.org.au/dentistry/>   * patients with Type 1 diabetes * blood dyscrasias or bleeding disorders * severe respiratory disorders * severe congenital heart disease   Young patients possibly requiring interceptive orthodontics will not be screened by Paediatric Dentistry unit. Instead, please refer to Orthodontics with a completed Orthodontic referral form. |
| **PREREQUISITES FOR REFERRAL** |
| Completed medical history    OPG provided, if able to.    For Caries Management:   * Oral health education sessions are booked at least every 3 months * Completed Caries management form     If referring for one specific issue, a detailed description of all other issues that are being managed by local clinic and a detailed management plan. |
| **GUIDANCE WHEN REFERRING to Paediatric Dentistry** |
| * Patients meeting the referral criteria will be offered a consultation to assess treatment requirements. * Patients assessed as needing procedures under General Anaesthesia will be placed on the appropriate waiting list by RDHM screening practitioners. Waiting times are generally shorter for procedures that can be performed under local anaesthesia with or without nitrous oxide sedation. |
| **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: |

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| ***Community Dental Clinic referring:*** |  |
| ***Community Dental Clinic mailing address:*** |  |
| ***Referring Clinician email:*** |  |

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| **PAEDIATRIC DENTISTRY CHECKLIST – 1. Caries Management (Clinicians to complete)** | |
| *Please complete all sections.  If details are missing the referral might be given a lower priority or declined* | |
| **Referrals for patients in pain:** | **More information about the pain:** |
| Nocturnal Pain  Pain affecting eating  Pain to thermal or mechanical stimuli | How long have the symptoms been present?    Other details, e.g., recurrent episodes of pain/abscess: |
| **Analgesia** | **More information about analgesia:** |
| ***Pain managed by analgesia***  Not required  Paracetamol prescribed: Dose  Ibuprofen contraindicated  Ibuprofen prescribed: Dose  Patient’s weight: kg |  |
| **Antibiotics** | **More information about cellulitis:** |
| ***Presence of facial cellulitis***  Not required  Previously has had facial cellulitis:  Prescribed:  Drug  Dose  Frequency  Duration | Details: |
| **Oral Health Education (OHE)** |  |
| Referrals will be rejected if OHE is not undertaken by the referring clinic.  This includes but not limited to appropriate fluoride use, toothbrushing instruction, diet counselling, application of topical fluoride or SDF and desensitization visits.  OHE sessions should be at least every four months. | Details regarding OHE recommended, improvements made by the family or lack thereof: |
| **Minimally Invasive Dentistry (MID)** |  |
| In general children requiring restoration of the primary dentition without signs or symptoms (clinical or radiographic) of pulp necrosis/infection are not suitable for referral to the paediatric department until MID approaches have been exhausted.  Consideration should be given to intense OHE, SDF, ART and Hall Crowns for disease management until cooperation and rapport are developed.  Exceptions to these requirements include children with special needs, significant medical history, significant anxiety or complex requirements. | MID approaches have been attempted, details:  MID approaches have not been attempted  If not, why? |

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| **PAEDIATRIC DENTISTRY CHECKLIST - 2. Special Needs Patients (Parents/Guardians to complete)** |
| For children and teenagers with special needs there are many stimuli in a dental surgery that may provoke anxiety. These may include noises, smells, bright lights, tastes, textures and the fear of the unknown. These questions are optional but may assist in planning for your child’s dental treatment.  These URLs provide links to social stories if you and your child find these a useful way to prepare  [StrategyAtWork\_VisitToDentistSocialStory.24121815.pdf (livingwellwithautism.com)](http://www.livingwellwithautism.com/yahoo_site_admin/assets/docs/StrategyAtWork_VisitToDentistSocialStory.24121815.pdf)  [Social Stories for Going to the Dentist – Pathfinders for Autism](https://pathfindersforautism.org/articles/healthcare/social-stories-for-going-to-the-dentist/)  [dentist-social-story.pdf (wordpress.com)](https://leechbabe.files.wordpress.com/2008/08/dentist-social-story.pdf) |
| **Please describe your child’s at home dental care.** |
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| **Does your child brush independently or with assistance?** |
| Can brush their teeth independently  My child requires assistance |
| **Please describe your child’s diet (are they fussy with flavours or textures)?** |
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| **Does your child communicate verbally? If not, how do they communicate?** |
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| **How does your child behave when they get anxious, frustrated or upset? How do you help calm them?** |
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| **How does your child cope with waiting at hospital or doctors?** |
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| **Does your child have any specific oral sensitivities (mint toothpaste or gagging)?** |
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| **Is there any additional information that may help us prepare for a successful dental appointment?** |
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