|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **For official use only:** | **Case No:** | |  | | | |
|  | | | | | | | | | | |
| **PART 1 - TO BE COMPLETED BY REFERRING DENTIST** | | | | | | | | | | |
| Date: | |  | | | | | | | | |
| Patient Name: | |  | | | | | | | | |
| Patient Address:  (Incl. postcode) | |  | | | | | | | | |
| Patient Contact No: | |  | | | | | | | | |
| Date of Birth: | |  | | | CHI (if known): | | |  | |
| Name of Referring Dentist: | |  | | | | Contact No: | | |  | |
| Practice Address: | |  | | | | | | | | |
| Reason for Referral / Treatment Required:  (Brief outline of clinical presentation) | |  | | | | | | | | |
| **Diagnosis and tooth:**  Treatment Requested: Extraction  Extirpation:  Other:  ***(please detail):*** | | | | | | | | |
| Relevant Medical History: | |  | | | | | | | | |
| Current Medication: | |  | | | | | | | | |
| Allergies: | |  | | | | | | | | |
| Has patient been given Advice / Analgesia / Antimicrobials?  Yes:  No: | | Give details and dates: | | | | | | | | |
| Are radiographs or photos available / attached?  Yes:  No: | | Give details and dates: | | | | | | | | |
| Is the patient in a high risk COVID-19 group? | | Yes:  No:  Is the patient shielding: Yes:  No: | | | | | | | | |
| COVID-19: | | Does the patient or anyone they live with have:  Cough:  Fever:  No symptoms:  Change in Smell or Taste: | | | | | | | | |
| Escort Required:  Yes:  No: | | Does the escort have symptoms of COVID-19?  Yes:  No: | | | | | | | | |
| Additional Notes: | |  | | | | | | | | |
| **PART 2 - TO BE COMPLETED BY VETTING DENTIST** | | | | | | | | | | |
| Vetting Dentist: | |  | | | | | | | | |
| Is an appointment at a UDCC required? | | Yes  No: | | | | | | | | |
| If Yes: | | Probable Diagnosis: | |  | | | | | | |
| Allocated to: | |  | | | | | | |
|  | |
| If No, give outcome: | | Prescription Issued:  Other ***(give details)*:** | | | | | | | | |
| **PART 3 - TO BE COMPLETED BY UDCC** | | | | | | | | | | |
| Has the patient attended? | | Yes  No: | | | | | | | | |
| If No give reasons: | |  | | | | | | | | |
| Date of Treatment: | |  | | | | | | | | |
| Dentist Providing Treatment: | |  | | | | | | | | |
| Treatment Provided: | |  | | | | | | | | |

**Email to:** [**nhshighland.dentalhelpline@nhs.net**](mailto:nhshighland.dentalhelpline@nhs.net)