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| --- | --- | --- |
| **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**