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| **PAEDIATRIC DENTISTRY REFERRAL FORM**  **(SPECIAL EDUCATION NEEDS SCHOOLS)** | | | | |
| **Surname:** | **First Name(s):** | | **Gender:** | |
| * Male * Female * Prefer not to say | |
| **Date of Birth:** | **NHS Number:**  (If known) | | **Is this referral urgent?**   * Yes * No | |
| Home Address: **Post Code: Borough:**  **Phone:**  **Mobile contact:** | | **GP Name :**  **GP Address:**  **Post Code: Borough:**  **Phone:** | | |
| **Interpreter Required?** | * Yes * No | **Which language?**  …………………………………………….  **BSL** 🞏 | | |
| **Medical History, Disability**  Is patient under hospital care for a medical reason?  **Y / N**  If yes, which hospital: | | **Medication** | | |
| **Name of Referrer & Relationship to child** | | | **Date of referral** | |
| **Name of School:** | | | **Date Received** (office use) | |
| **School Address:**  **Post Code:** | | | **Phone / Mobile:**  **Secure Email:** | |

**Please email this completed form to** [**kch-tr.cdsepiscreen@nhs.net**](mailto:kch-tr.cdsepiscreen@nhs.net)