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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**