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|  | **Dental Services Referral Form- PROSTHODONTIC CLINIC**  **Date:** |

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| **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:** |  |
| **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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| **PROSTHODONTIC UNIT – OVERVIEW** |
| The Prosthodontic unit manages oral conditions associated with missing or deficient teeth and/or deficiencies of the face and jaw beyond the scope of a general dental practitioner. The unit offers a range of restorative modalities, with each procedure having its own cost/benefit implications. The treating practitioner provides treatment options and helps determine the final choice of modality after assessment and consideration of all relevant factors (clinical, patient and costs).  The prosthodontic unit will provide the following services:   * Opinion via referral * Assistance and advice in developing treatment plans * Active treatment/management * Mentoring and professional development   A referral to the Prosthodontics Unit may result in the following outcomes:   * No treatment is warranted * Natural teeth are replaced with: * removable partial or complete dentures, * crowns and bridges, * implant retained over dentures, * implant-supported crowns/bridges. |
| **COMPLEX PROSTHODONTIC AND DENTAL IMPLANT THERAPY** |
| A limited number of cases may be considered for the provision of complex prosthodontic and dental implant treatment through the Melbourne Dental School (MDS) Teaching Programs via patients already accepted by RDHM Prosthodontic Unit. Please refer to pages 2 & 3 of the Referral for Specialist Dental Care Procedure. |
| **MAINTENANCE OF DENTAL IMPLANTS** |
| Only cases where the implant therapy was provided at the RDHM will be accepted for maintenance in the specialist or postgraduate teaching clinics. |
| **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. |

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| **CLINICAL CRITERIA FOR REFERRAL** |
| Patients who have lost an anterior tooth/teeth or have a tooth/teeth of poor prognosis particularly following trauma, and who otherwise, have intact arches and a sound dentition.  Patients missing one or more teeth due to trauma, anodontia, genetic conditions, or diseases of the jaws. For example, osteomyelitis, tumours.  The presence of compromised function:   * where there are less than 10 functional occlusal units (shortened dental arch) resulting in difficulties in speaking or eating, * where patient dignity is affected due to the missing of a tooth or missing teeth in the aesthetic zone   When the provision of a conventional fixed prosthesis will beneficially protect damaged teeth |

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| **EXCLUSION CRITERIA** |
| * The management of unsuccessful, failing or failed complex crown & bridge restorative work done externally is restricted. In these cases, the like for like replacement of these prostheses is out of scope for referral to RDHM * For externally placed dental implants and restorations, the like for like replacement of the prostheses will not be accepted by RDHM. The scope of treatment does not include any repair of existing implant prostheses or replacement with a new fixed implant prosthesis |
| **PREREQUISITES FOR REFERRAL** |
| Completion of all general dental care prior to referral with a statement of confirmation  A diagnostic quality OPG radiograph less than 12 months old  Bitewing and periapical views of diagnostic quality as appropriate  Accurate medical history  Demonstrated ability to maintain excellent oral hygiene < 15% plaque score, (shown in a minimum of 2 O'Leary plaque index scores) |
| **GUIDANCE WHEN REFERRING to Prosthodontics** |
| * Referring practitioners should gauge and manage patient’s expectations before referring to the RDHM. * Patients should not expect or commit to a particular treatment modality or procedure. * A suitable treatment plan will only be offered following a comprehensive assessment. * Patients must be prepared for either non-acceptance of the referral or a treatment plan which includes alternative treatments including no treatment. * Any need for an immediate denture is expected to be provided by the patient’s general dentist * Emergency, general and supportive care will be provided at the community agency during a possibly long waiting period. A recall exam prior to the first RDHM specialist visit is recommended. * On discharge from Prosthodontics unit community dental agency will be responsible for any ongoing maintenance. * A new referral to RDHM will be required for reviews or any new problems |
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| **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 / Responsible person’s 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.**  **It is essential that the restorative treatment plan is included.** |
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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 |  | | Detail significant risk(s): | | | | | | |

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