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|  | **Dental Services Referral Form- Oral Medicine- OROFACIAL PAIN CLINIC****Date:**        |

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| --- | --- | --- | --- | --- |
| **DRN/UR** | **Title:**  | **Surname** | **Given name** | **Date of birth:** |
|       |       |       |       |       |

|  |  |  |
| --- | --- | --- |
| **Street address** | **Suburb** | **Postcode** |
|       |       |       |
| **Name of Residential Facility (if applicable)** |
|      Room:       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Phone - Home:** |       | **Mobile:** |       | **Work:** |       |

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| --- | --- | --- | --- |
| **Country of birth:** |       | **Cultural background:** |       |

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| --- | --- | --- | --- |
| **Needs interpreter:**  |  **[ ]  Yes [ ]  No** | **Language:** |       |
| **Indigenous status:** |       :  |
| **Priority access:** |  |

|  |  |
| --- | --- |
| **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:

|  |  |
| --- | --- |
| **Person Responsible name:** |       |
| **Relationship to patient:** |       | **Phone:** |       |
| **Address:** |       |

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| **ORAL MEDICINE UNIT - OVERVIEW** |
| The Oral Medicine Unit is responsible for the diagnosis, prevention and predominantly non-surgical management of oral mucosal disease, chronic orofacial pain and the oral manifestations of systemic disease. This includes oral dermatoses, oral malignancies, temporomandibular disorders, oral dysaesthesias and pain of neuropathic origin. Oral Medicine may accept referrals from dental practitioners ***as well as medical and other health practitioners***.  |
| **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. |
| **URGENT MANAGEMENT ORAL MEDICINE PATIENT REFERRALS** |
| The referring practitioner is to contact RDHM Oral Medicine Unit on **(03) 9341 1120** to ensure appropriateness of referral & ascertain the ability of the clinic to coordinate care on the day.   Conditions that may require urgent referral management include: (Urgency 1)  **[ ]** Suspected malignancy **[ ]** Patients suspected to have Trigeminal neuralgia The patient must be provided with a completed Oral Mucosal Referral or Orofacial Pain Referral Form and any available radiographs and directed to proceed to the main hospital reception after an appointment has been organised.  Due to demand, it may not be possible to provide the care proposed for a particular patient on the same day. **Prior phone notification and confirmation of the receipt of the referral is essential.** |
| **REFERRAL CRITERIA – OROFACIAL PAIN CLINIC**  |
| **[ ]** Temporomandibular Disorders (TMD)**[ ]** Oral dysaesthesias**[ ]** Suspected Trigeminal Neuralgia**[ ]** Chronic orofacial pain where an odontogenic cause has been excluded**[ ]** Obstructive Sleep Apnoea (OSA) |
| **EXCLUSION CRITERIA**  |
| * Bruxism without signs or symptoms of Temporomandibular Disorder (TMD)
* Odontogenic pain
 |
| **PRE-REQUISITES FOR REFERRAL**  |
| [ ]  Patients with TMD need to complete all general dental care, with a statement of confirmation[ ]  Patients with OSA need a recommendation from sleep specialist with sleep study <12 months |

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|  **REASON FOR REFERRAL** **– OROFACIAL PAIN CLINIC** |
| **[ ]** 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):**   |
|    |
|  **Details for the referral:** |
|   |
|  **Provisional or Definitive Diagnosis**  |
|   |
|  **Briefly describe how the service requested fits in your overall treatment plan.**  |
|   |

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| **Summary of medical history:**  |
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| --- | --- | --- |
| **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 | [ ]  |
| *Details of other risks:* |

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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:      |
|  [ ]  Medical Practitioner (see bottom three items)  | For Students:  |
| ***Community Dental Clinic referring:***  |       |
| ***Community Dental Clinic mailing address:***  |                 |
| ***Referring Clinician email:***  |       |
| ***Medical Practice Clinic referring:*** |       |
| ***Medical Practice Clinic mailing address:***  |                 |
| ***Medical Practice Clinic email address:***  |       |

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| **Ongoing care required by referring clinician** |
| By submitting this referral, I on behalf of the referring clinic, agree to:[ ]  Ensure that appropriate symptomatic relief is provided to the patients as required [ ]  Overall general care to this patient while on the waiting list |