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|  | **Dental Services Referral Form- INTEGRATED SPECIAL NEEDS****Date:**       |

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

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

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| **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:** |  |

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| **Concession Card type:** |  |
| **Concession Card No:** |       | **Expiry date:** |       |
| **Medicare Card:** |  Patient no.       |
| **Medicare Card No:** |       | **Expiry date:** |       |

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| **Consent** |
| In situations where the patient cannot provide self-consent or the clinician is not satisfied that the person is capable of providing informed consent, consent needs to be provided by the ***Person Responsible***. If additional examination findings determine that there will be a different treatment plan, these are to be provided in writing or by telephone to the Person Responsible to gain consent for additional or altered dental treatment.  |

**For patients unable to provide self-consent:**

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

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| **INTEGRATED SPECIAL NEEDS DENTISTRY UNIT - OVERVIEW** |
| The Integrated Special Needs Dentistry Unit accepts adult patients (**18 years OR older on referral**) who have special needs. Special Needs may include:* Physical disability, for example Cerebral Palsy
* Intellectual disability, for example Down Syndrome
* Complex medical issues, for example patients who have cancer treatment to the head or neck
* Patients who are homebound
 |
| **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** |
| **Physical and Intellectual Disabilities:****[ ]** Patients with physical disability and behavioural issues where the ability to understand and cooperate during dental treatment is so limited that there is a risk of injury or likelihood that the treatment cannot be completed predictably in the dental chair**Complex Medical Issues:****[ ] [ ]** There is a significant risk of a deterioration of a medical condition if dental treatment is delayed OR**[ ] [ ]** There is a significant risk of the proposed treatment adversely impacting the patient’s medical condition AND**[ ] [ ]** The patient has a medical condition that impacts on the provision of dental care that cannot be managed by a general dentist safely or predictably**Patients who are homebound:****[ ] [ ]** Patients who have significant difficulty accessing a dental clinic for example, patients living in:[ ]  **[ ]** Residential aged care[ ]  **[ ]** Supported residential setting[ ]  **[ ]** Supported private accommodation |
| **EXCLUSIONS** |
| Patients aged 16 years or under should be referred to the Paediatric Dentistry Unit |
| **Prerequisites for Referral** |
| **[ ]** A detailed medical history from the patient’s general practitioner **[ ]** Consent to be provided by the patient or the Medical Decision Maker. More information can be found at:<https://www.publicadvocate.vic.gov.au/medical-consent/>**[ ]** Any recent radiographs **[ ]** Attached **[ ]** Not applicable **[ ]** Referring dentists are to provide care and treatment aiming to stabilise disease, prevention and maintenance at their local clinic. Referring dentists are to discuss with the senior dentist to establish that the patient’s care is outside the scope of all senior practitioners at the clinic. |

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| **GUIDANCE FOR CARERS** |
| Patients with special needs who have carers assisting them to live at home or in residential care MUST be accompanied by one or more carers at an appointment.  |

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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 / Person Responsible 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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| **INTEGRATED SPECIAL NEEDS UNIT** |
| **Summary of medical history: (please attach patient’s current full history)** |
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| **Notable issues** | **Summary information** | **Details attached** |
| Physical or sensory impairment | [ ]  Sight | [ ]  Hearing | [ ]  Physical | [ ]  Nil known | [ ]  |
| Intellectual impairment | [ ] Learning | [ ]  Behaviour | [ ]  Nil known | [ ]  |
| Communication Preferred method | [ ]  Auslan | [ ]  Non-Verbal | [ ]  Blinking | [ ]  |
| [ ] Electronic device | [ ]  Communication Board | [ ]  Nil known |
| Swallowing problems | [ ] Modified diet | [ ]  Thickened drinks | [ ]  Supported feeding | [ ]  |
| Falls Risk / Pressure Ulcers | [ ]  Falls Risk | [ ]  Pressure Injuries | [ ]  Nil known | [ ]  |
| Medications | [ ]  Prescribed | [ ]  Self-administered | [ ]  Nil known | [ ]  |
| Allergies / ADR | [ ]  Allergies | [ ]  Adverse Drug Reaction | [ ]  Nil known | [ ]  |
| Other significant risks  | [ ]  Yes | [ ]  No | [ ]  Nil known | [ ]  |
| Details of other significant risk(s):       |

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| **Does this patient require support service 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:***  |       |