|  |
| --- |
| **Patient details** |
| Name of adult |  |
| What does the adult like to be called |  |
| Date of birth |  |
| Gender |  |
| NHS number (if known) |  |
| Address |  |
| Name of carer if applicable  |  |
| Contact telephone number of carer if applicable |  |
| Email address of carer if applicable |  |
| Relevant Medical History |  |
| Relevant Dental History including recent urgent care provision  |  |
| Translator Required If Yes – Language required: | Yes [ ]  No [ ]  |
| Communication requirements |  |
| Is the Adult | Clinically Vulnerable? Yes [ ]  No [ ] Has Tooth Surface Loss? Yes [ ]  No [ ] Has Dementia? Yes [ ]  No [ ] Is Homeless? Yes [ ]  No [ ] Has /Is Smoking, Alcohol or Drug dependant, weight management? Yes [ ]  No [ ] Has Diabetes? Yes [ ]  No [ ]  |
| **Details of Adults registered GP**NamePractice AddressPhone numberEmail address |  |
| **If applicable:****Details of the social worker/other key worker who is supporting the Adult?**NameTitle/roleAddressPhone numberEmail address |  |

**Referrer Details**

|  |  |
| --- | --- |
| Name of referrer and role |  |
| GDC number |  |
| Contact details:AddressTelephone numberSecure email address (nhs.net or gov.uk) |  |

**Please Tick to Confirm**

The patient does not currently regularly see an NHS Dentist. [ ]

Person with parental responsibility consents to share personal information with the dental practice accepting the referral. [ ]

For patients under 16 years, person accompanying the patient will be able to give consent for treatment (if not possible please describe the arrangements for consent in the space [ ]  below).

Parent/carer understands that if the CYP fails to attend their dental appointment or contact cannot be made, the dental practice may share this information for safeguarding purposes [ ]

**Produced July 2024**

**Please email completed forms to** **mydentist.Keighley@nhs.net**