|  |
| --- |
| **Patient details** |
| Name of child or young person (CYP) |  |
| What does the CYP like to be called |  |
| Date of birth |  |
| Gender |  |
| NHS number (if known) |  |
| Address |  |
| Name of parent/carer |  |
| Contact telephone number of parent/carer |  |
| Email address of parent/carer |  |
| Relevant Medical History |  |
| Relevant Dental History including recent urgent care provision  |  |
| Translator Required If Yes – Language required: | Yes [ ]  No [ ]  |
| Communication requirements |  |
| Is the CYP | On a child protection plan? Yes [ ]  No [ ] A Child Looked After (Looked After Child)? Yes [ ]  No [ ] Supported by Early Help or a Children & Families Worker? Yes [ ]  No [ ] Supported by the Healthy Child Team (0-19) Practitioner? Yes [ ]  No [ ] Cared for by the Local Authority? Yes [ ]  No [ ] A Care Leaver? Yes [ ]  No [ ]  |
| **Details of CYP’s registered GP**NamePractice AddressPhone numberEmail address |  |
| **If applicable:****Details of the social worker/other key worker who is supporting the CYP (e.g., if on a Child Protection Plan or a Looked After Child)**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 (CYP) 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 [x]

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