NHS England

PAEDIATRIC DENTISTRY REFERRAL FORM
(SPECIAL EDUCATION NEEDS SCHOOLS)

Surname:	**First Name(s):**	**Gender:** ☐ Male ☐ Female ☐ Prefer not to say
Date of Birth:	**NHS Number:** (If known)	**Is this referral urgent?** ☐ Yes ☐ No

Home Address: **Post Code:** **Borough:** **Phone:** **Mobile contact:**	**GP Name :** **GP Address:** **Post Code:** **Borough:** **Phone:**
Interpreter Required? ☐ Yes ☐ No	**Which language?** .... **BSL** ☐
Medical History, Disability Is patient under hospital care for a medical reason? **Y / N** If yes, which hospital:	**Medication**
Name of Referrer & Relationship to child	**Date of referral**
Name of School:	**Date Received** (office use)
School Address: **Post Code:**	**Phone / Mobile:** **Secure Email:**

Please email this completed form to kch-tr.cdsepiscreen@nhs.net