DOMICILIARY REFERRAL PROFORMA

OXFORDSHIRE COMMUNITY DENTAL SERVICE

NHS Oxford Health NHS Foundation Trust

PATIENT'S NAME .....

D.O.B. .....

MALE ☐ FEMALE ☐

ADDRESS .....

.....

.....

POSTCODE .....

☎ (H).....

(Mob.) .....

NEXT OF KIN.....

RELATIONSHIP.....

ADDRESS .....

.....

.....

POSTCODE .....

☎ (H).....

(Mob.) .....

REFERRER (e.g. Social Worker, Health Visitor, Nursing Home Manager, Doctor, Dentist, relative)

(please specify).....

NAME.....

ADDRESS .....

.....

.....

POSTCODE .....

☎ .....

DOCTOR .....

ADDRESS .....

.....

.....

POSTCODE .....

☎ .....

MOBILITY ASSESMENT

DATE OF REFERRAL.....

REASON FOR DOMICILIARY REFERRAL

☐ Loose, broken or ill-fitting dentures

☐ Lost dentures

☐ Lost filling /broken tooth

☐ Other (please give details).....

.....

.....

☐ Currently in pain

SENSORY IMPAIRMENT (please give details)

☐ Hearing.....

☐ Vision.....

☐ Communication.....

Any additional information.....

.....

.....

MEDICAL HISTORY

Medical Problems.....

.....

.....

.....

.....

.....

Medication.....

.....

.....

.....

Allergies.....

.....

DOMICILIARY REFERRAL PROFORMA

OXFORDSHIRE COMMUNITY DENTAL SERVICE

Oxford Health NHS Foundation Trust

Does the patient go out at all?	Yes ☐	No ☐
Can they walk unaided?	Yes ☐	No ☐
Can they walk with assistance?	Yes ☐	No ☐
Are they a wheelchair user?	Yes ☐	No ☐
Are they bed bound?	Yes ☐	No ☐

ELIGIBILITY CRITERIA FOR DOMICILIARY CARE

How does the patient get to their Doctor?

.....

If the patient has a hospital appointment, how does he/she get there?

.....

When was the last time the patient was able to leave the house?

.....

Does the patient have someone to bring them to the surgery?

Yes ☐ No ☐ Don't know ☐

Does the patient use a taxi for other activities?

Yes ☐ No ☐ Don't know ☐

Does the patient receive the mobility component of Disability Living Allowance?

Yes ☐ No ☐ Don't know ☐

Please explain why you feel the patient is unable to attend a clinic for treatment?

.....

.....

.....

Please ensure you have fully completed ALL three documents (domiciliary referral form, orange PR patient charges form and medical history questionnaire) to avoid delays in processing your referral. Please note we can no longer accept faxed referrals.

NHS
Oxford Health
NHS Foundation Trust

OXFORDSHIRE COMMUNITY DENTAL SERVICE

MEDICAL HISTORY

R4 Number .....

Title Mr, Mrs, Ms, Miss, Other	**Telephone Numbers:** Please indicate the number which is your contact preference
Surname .....**MALE/FEMALE** (Please delete as necessary)	**Home** ..... ☐
Forenames	**Work**..... ☐
Date of Birth.....	**Mobile No.**..... ☐
Address.....	**Next of Kin Name**.....
.....	**Contact Tel. No.** .....
.....**Post Code**.....	The Trust helps you by sending reminders by text about your appointments. If you do not want to receive such a message please let us know.

Who is your family doctor?.....

Practice Address .....

Please answer all questions YES or NO by ticking the appropriate boxes and give additional information where requested. The condition may exist now or in the past. **If you do not understand any question you must tell the dentist.**

	YES	NO	If yes give details
History of heart trouble?	☐	☐	.....
High blood pressure, Heart disease or Heart Surgery	☐	☐	.....
Heart murmurs, Rheumatic Fever	☐	☐	.....
History of chest problems?	☐	☐	.....
Asthma	☐	☐	.....
Bronchitis or other chest disease	☐	☐	.....
Do you smoke?	☐	☐	.....
If so, how many a day?	☐	☐	.....
History of steroid medication? If so when, how long for and what dose?	☐	☐	.....
Are you taking the Contraceptive Pill or any other hormone treatment?	☐	☐	.....
Medication taken to thin the blood and prevent clotting? (e.g. aspirin, Warfarin.)	☐	☐	.....
Any problems with bleeding after a cut or surgery?	☐	☐	.....

Please give details of all medication you are currently taking or have taken recently.....

.....

.....

History of diabetes?	☐	☐	
Insulin or tablet controlled	☐	☐	.....
Diet controlled	☐	☐	.....
History of Allergies? (e.g. Penicillin, eggs, soya, rubber gloves.)	☐	☐	.....

Please turn over

	YES	NO	If yes give details
History of epileptic fits, febrile convulsions or fainting?	☐	☐	.....
In the case of epilepsy how frequent are the fits and what medication is taken to control it?			
Have you ever had Hepatitis or Jaundice?	☐	☐	.....
History of Rheumatoid Arthritis?	☐	☐	.....
Have you ever had a general anaesthetic?	☐	☐	.....
What was this for?			.....
Have you or any relatives had a reaction to a General Anaesthetic?	☐	☐	.....
			.....
Do any relatives come from the Middle East, Mediterranean or Afro-Asian countries?	☐	☐	.....
Family History of Sickle cell/Thalassaemia	☐	☐	.....
Has anyone in your family suffered from CJD?	☐	☐	.....
Did you receive growth hormone treatment before the mid 1980's?	☐	☐	.....
Are you pregnant?	☐	☐	.....

How much alcohol do you consume weekly? ..... **units**

Height ..... **Weight** .....

History of any other serious medical/physical condition that may affect your care including learning disability, autistic spectrum, behavioural or mental health problems?

.....

.....

.....

.....

.....

The medical history sheet has been completed and the questions answered as fully as I am able

Signed..... **Print Name**.....
(Parent/Guardian/Patient/Carer/Support Worker)

Date ...../...../.....

I have checked the completed medical history and I am satisfied that the person who has completed it is competent to do so.

Signed.....**(Dentist) Date**...../...../.....

Updates to be made at beginning of every episode of care or every six months.
The medical history has been checked and amended (initialled and dated on the above form) and is now up to date in all respects.

Date Checked	Amended (Yes or No)	Signature (Parent/ Guardian/ Patient)	Name (Parent/ Guardian/ Patient)	Dentist's Signature

PR (01/05/2022 R9) Practice Record Form - Patient Declaration

NHS

ONE FORM MUST BE COMPLETED FOR EACH COURSE OF TREATMENT

This form is to be retained in the Dental Practice unless requested by the NHSBSA or other authorised body

PATIENT INFORMATION (TO BE COMPLETED BY THE DENTAL PRACTICE)

Provider name, address and location number

Patient's NHS Number

SURNAME (in CAPITALS)

FORENAME (in CAPITALS)

Date of Birth D D M M Y Y Y Y

ETD Claim Reference Number

Evidence of exemption or remission seen Yes ☐ No ☐

Date of acceptance Day D D Month M M Year Y Y

Date of Completion or last visit Day D D Month M M Year Y Y

THE REMAINDER OF THIS FORM MUST BE COMPLETED BY, OR ON BEHALF OF, THE PATIENT

PATIENT DECLARATION (TO BE COMPLETED FOR ALL PATIENTS)

I consent to the dental provider named above, or their representative, to examine me under the NHS and to give me any necessary care and treatment that I am willing to undergo within NHS arrangements. I agree to pay the statutory charges for the NHS dental service I receive, unless I have completed a valid claim for free or reduced cost NHS dental services below, and that I may have to pay the full amount prior to treatment. I agree, if necessary, to be examined and/or to have my dental records examined by the NHS Business Services Authority (NHSBSA) or other authorised bodies. I declare that the information I give on this form is correct and complete. I understand that if it is not, appropriate action may be taken against me.

Signature **Date**

If you are signing for the patient give details below:

Name (in CAPITALS)

Relationship to patient

To enable the NHS to prevent and detect fraud and mistakes, pay dentists and to secure the effective and efficient delivery of NHS and related services, relevant information on your NHS treatment may be shared with, and by the NHSBSA to NHS England, Department for Work and Pensions, HM Revenue & Customs, NHS Digital, NHS Counter Fraud Authority, NHS Service Commissioners and bodies performing functions on their behalf. Your personal data will be deleted within 8 years of receipt into our systems. Further details are available at **www.nhsbsa.nhs.uk/yourinformation**

What is your ethnic group?

Please choose **ONE** selection from this list to indicate your ethnic group:

- ☐ White British
- ☐ White Irish
- ☐ Other white background
- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Other mixed background
- ☐ Asian or Asian British Indian
- ☐ Asian or Asian British Pakistani
- ☐ Asian or Asian British Bangladeshi
- ☐ Other Asian background
- ☐ Black or Black British Caribbean
- ☐ Patient declined
- ☐ Black or Black British African
- ☐ Other Black background
- ☐ Chinese
- ☐ Any other ethnic group

Please provide your email address and/or mobile number

Email Address

Mobile Number

Please note, your email address and/or mobile number held by this dental practice will be submitted to the NHSBSA for this course of treatment.
Please be assured the NHSBSA will only use this information to survey you about the NHS Dental treatment you have received.
If you do not want to share your email address and/or mobile number with the NHSBSA please indicate here **Email** ☐ **Mobile number** ☐

CLAIM FOR FREE OR REDUCED COST NHS DENTAL SERVICES

YOU MUST READ THIS FORM BEFORE YOU SIGN IT. ONLY SIGN IT IF IT IS CORRECT.

The patient is responsible for the accuracy of this claim, NOT the dental practice.
If you're not certain that you're entitled to receive free or reduced cost NHS dental services you MUST pay the dental practice. If you subsequently confirm that you were entitled to free or reduced cost dental services, you can claim a refund. If you have applied for a qualifying benefit or exemption certificate but have not received it yet, you must pay and claim a refund when/if you do receive it.
Checks on claims are undertaken to confirm you are entitled. Incorrect claims for free or reduced cost NHS dental services will result in a penalty charge of up to £100, in addition to the cost of NHS dental services.
You won't have the opportunity to pay for the services first to avoid the penalty charge.

a) I am entitled to free NHS dental services because on the first day of treatment:

- ☒ **I am under 18 years of age.**
- ☒ **I am 18 years of age and in full time education** — Enter Name of college or university
- ☒ **I am pregnant** } NHS Maternity Exemption certificate/card no.
- ☒ **I had a baby in the last 12 months** } Date baby due/born D D M M Y Y
- ☒ **I am currently in prison or a young offenders institution**

b) I am entitled to free NHS dental services because during the course of treatment I get, or am included in an award (as a claimant, partner, or dependent person under 20) of:

- ☒ **Income Support** (Incapacity benefit and Disability Living Allowance does **NOT** count)
- ☒ **Income-based Jobseeker's Allowance** (Contribution-based does **NOT** count)
- ☒ **Income-related Employment & Support Allowance** (Contribution-related does **NOT** count)
- ☒ **Pension Credit Guarantee Credit** (Savings Credit on its own does **NOT** count)

Please complete details below

Print name of person receiving benefit

Date of Birth D D M M Y Y Y Y

Enter National Insurance Number

- ☒ **Universal Credit and meets the criteria.** *Find out more at* **www.nhsbsa.nhs.uk/UC**

DURING THE COURSE OF TREATMENT THESE ARE THE ONLY BENEFITS THAT ENTITLE YOU TO FREE NHS DENTAL SERVICES

c) I am entitled to free NHS dental services because I am named on one of the following certificates that is valid during the course of treatment:

- ☒ **HC2 Certificate** — Enter Certificate Number
- ☒ **NHS Tax Credit Exemption Certificate/Card** (or entitled to one) — Enter Certificate/card Number

(You are not automatically entitled because you receive Tax Credits; there are qualifying conditions, please check at www.nhs.uk/healthcosts. If you qualify you will be sent an exemption certificate/card, but if you don't have one you can use the award notice as proof).

d) I am entitled to reduced cost NHS dental services because:

- ☒ **I am named on a HC3 certificate that is valid during the course of treatment which limits the amount I have to pay to** £ _____ Enter Certificate Number

I confirm that the information I have given above is correct and complete and that I am entitled to free or reduced cost NHS dental services as above. **I understand that I will have to pay for my treatment and a penalty charge of up to £100, if it is not correct and I am not entitled.**

Signature _____ Date _____

If you are signing for the patient give details below:

Name (in CAPITALS) _____

Relationship to patient _____