Appendix 1; Standardised Referral Form

Specialist Periodontal Service Referral Form

<table>
<tr><td colspan="2">Patient Name and Address: (Please check with patient if this is correct)

Postcode:
Daytime telephone:
Mobile:
E-mail:

Patient DOB:
Date of Referral:

Referred to: Brace ☐ Waterside ☐</td><td>Referring Practitioner (Stamp)

Signature of Dentist:

Name and Address of General Medical Practitioner:</td></tr>
<tr><td>High quality, relevant radiographs enclosed ☐
(mandatory)</td><td>Oral Hygiene:
Excellent ☐ Good ☐
Fair ☐ Poor ☐</td><td>BPE Score in Each Sextant
<table><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></table></td></tr>
<tr><td colspan="3">Reason for Referral (Please tick the appropriate box)
☐ Patient has BPE scores of 4 in at least one sextant <u>and</u> a medical factor affecting the periodontal tissues <u>or</u> complicated root morphologies/anatomical factors <u>or</u> a modifying factor (see Modifying Factors on page 2)
☐ Patient has BPE scores of 4 in a least one sextant and has not responded to previous periodontal treatment

☐ Patient has aggressive periodontitis based on the severity of disease for age or rapid rate of periodontal breakdown (> 2mm attachment loss/year)

☐ Patient requires surgical procedures involving tissue augmentation, bone removal or implants

☐ Other reason (Please specify)..
....
....
....</td></tr>
</table>

Modifying Factors *(Please tick the appropriate box)*

☐ Patient has a medical factor directly affecting the periodontal tissues (i.e. diabetes, medication) or adverse drug effects)

☐ Regular smoker or paan user

☐ Other (Please specify)..

....

Relevant Medical History *(e.g. history of head/neck radiotherapy, immune-compromised or immune-suppressed patient, bleeding disorders, or drug interactions)*

Preliminary Periodontal Treatment Carried Out by GDP *(No referral will excepted unless the patient has been provided with initial treatment and supportive therapy)*

PCT charge collected (£): Yes ☐ Amount £______ No ☐ Exempt ☐

Provider Use Only					
Returned (inappropriate referral)					
Referred to hospital					
Date of first Appointment					
Dates of Treatment	2nd visit	3rd visit	4th visit	5th visit	6th visit