UNIVERSITY OF PORTSMOUTH

# GDP REFERRAL FORM FOR PAEDIATRIC PATIENTS (under 16yrs)

| | | | | | | |
|---|---|---|---|---|---|---|
| **Date of referral** | | **Patient's Date of Birth** | | **Gender** (please tick) | **Male** | **Female** |
| | | | | | | |

| | | | |
|---|---|---|---|
| **Patient's Surname** | | **Patient's Forename** | |

| | |
|---|---|
| **Name of person(s) with parental responsibility:** | |

| | | | |
|---|---|---|---|
| **Contact Address**<br><br>**House Name or number and street name.** | | | |
| **Town of City** | | **Postcode** | |

| | | | |
|---|---|---|---|
| **Daytime Phone** | | **Mobile Phone** | |

| | |
|---|---|
| **Does your patient need to communicate in a language or mode other than English? If yes please specify.** | |

**GDP Stamp / Address**

| | |
|---|---|
| **Telephone number** | |

| | |
|---|---|
| **I confirm that the patient is able to cope with treatment under local anaesthesia. (does not require GA or sedation).** | |
| **Please tick to confirm** | |

| | |
|---|---|
| **I confirm I have informed the patient of the reason for referral and that treatment will be undertaken by students.** | |
| **Please tick to confirm** | |

| | |
|---|---|
| **I confirm that the person with Parental Responsibility will accompany the patient to appointments.** | |
| **Please tick to confirm** | |

| | |
|---|---|
| **I confirm that recent radiographs are included (no more than 6 months old)** | |
| **Please tick to confirm** | |

| | |
|---|---|
| **Print Name (Dentist)** | |

| | |
|---|---|
| **Signed (Dentist)** | |

**Please give details of radiographs sent and radiograph reports:**

**Please outline treatment needs identified:**

**Please provide medical history:**

**Please provide any other information relevant to this referral:**

**Please send completed forms to: GDP Referrals, Dental Academy Reception, William Beatty Building Hampshire Terrace, Portsmouth PO1 2QG. Any queries please telephone: 02392 845276**