MELBOURNE
Dental Clinic

Special Needs Dentistry Referral

Patient Name: _____ Date of Birth:___/___/___ Gender:_____

Address:_____

_____

Phone:_____ Mobile:_____ Email:_____

Type of residence: ☐ Own ☐ SRS ☐ CRU ☐ Hostel ☐ Nursing Home

Level of care: ☐ High ☐ Low Aboriginal or Torres Strait Islander: ☐ Yes ☐ No

Name of Carer: _____Carer's Contact Phone:_____

Patient can provide self consent: Yes ☐ No ☐ **If No:** Consent is given by the person responsible for the patients medical and dental care? Yes ☐ No ☐

Consent is given for (insert patient name)_____ to receive dental examination and dental treatment to be provided by a dentist from the MDC Special Needs Dentistry Unit.

Name: _____ Signature _____

Address: _____

_____

Relationship to the patient:_____Date: ___/___/___

Reason for Referral: ☐ Dental Checkup ☐ Toothache ☐ Denture Problems ☐ Emergency treatment ☐ Complete course of treatment ☐ Other (please describe)_____

Have you been seen at Melbourne Dental Clinic before: Yes ☐ No ☐

If yes, when:_____

Have you been seen by the Special Needs Unit before: Yes ☐ No ☐

If yes, when:_____

Have you had a general anaesthetic for dental treatment before: Yes ☐ No ☐

If yes, when:_____

Please turn over.

For all appointments P: 03 9035 8402 • F: 03 9035 9797 • E: mdc-bookings@unimelb.edu.au

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Special Needs Dentistry Referral Medical Questionaire

Patient Name: _____

Current Medication:

Please specify current prescription and over the counter medications: _____

_____

_____

Drug alergies: Yes ☐ No ☐ If yes, please describe_____

_____

Medical History:

Please specify past and current medical conditions and hospitalisations (please not any bleeding problems, history of rheumatic fever and prosthetic implants). Please attach another list if required.

_____

_____

_____

Is the patient capable of communication and/or comprehension? Yes ☐ No ☐

Do you normally make house calls for this patient? Yes ☐ No ☐

Do you consider this patient to be housebound? Yes ☐ No ☐

If yes please specify why_____

Is there any contraindications to extraction under local anaesthetic? Yes ☐ No ☐

Will this patient need antibiotic cover if any extraction of teeth is required? Yes ☐ No ☐

Has the patient had a dura matter graft or major neurosurgery between 1972-1989? Yes ☐ No ☐

Does the patient have a family history of 2 or more first-degree relatives with Creutzfeld-Jacob Disease (CJD) or other unspecified preogressive neurological disorder? Yes ☐ No ☐

Has the patient suffered from a recent progressive dementia (of less than 12 months duration), the cause of which is undiagnosed? Yes ☐ No ☐

Has the patient received human pituitary hormones prior to 1986 Yes ☐ No ☐

Is there anything else regarding this patient's condition which you feel is relevant to the provision of their dental treatment? (E.g. swallowing problems, physical problems, behavioral problems)

_____

_____

Medical Practitioner Details:

Name: Dr. _____

Address: _____

Phone: _____ Email:_____

Provider Number: _____

Medical Practitioner's Signature: _____ Date: ___/___/___