

## GDS Triage Referral Form

Date :	
Patient Name : Male <input type="checkbox"/> Female <input type="checkbox"/>	
Patient Address (inc postcode) :	
Patient Contact Number :	
Date of Birth :	
CHI No (if known) :	
Name of Referring Dentist :	
Practice Address :	
Dentist Contact Number :	
Reason for Referral/Treatment Required: (Brief outline of clinical picture)	Diagnosis and tooth: Outcome : Extraction <input type="checkbox"/> Extirpation <input type="checkbox"/> Other <input type="checkbox"/> .....
Relevant PMH :	
Meds :	
Allergies :	
Has patient been given Advice/Analgesia/Antimicrobials ? YES <input type="checkbox"/> NO <input type="checkbox"/>	Give details and dates :
Are radiographs or photos available and attached ? YES <input type="checkbox"/> NO <input type="checkbox"/>	Give details and dates :
Is the patient in a high risk group for becoming seriously ill ? (see SDCEP document)	YES <input type="checkbox"/> NO <input type="checkbox"/> Is the patient shielding YES <input type="checkbox"/> NO <input type="checkbox"/>
COVID-19 screen	Does the patient or anyone they live with, have: Cough <input type="checkbox"/> Fever <input type="checkbox"/> No symptoms <input type="checkbox"/>
Escort : YES <input type="checkbox"/> NO <input type="checkbox"/>	Does the escort have symptoms of COVID-19 ? YES <input type="checkbox"/> NO <input type="checkbox"/>
Additional Notes :	
<b>Section below for PDS use only</b>	
Triaging Clinician :	
Has the patient to be appointed to clinic ?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If Yes ;	Diagnosis and Outcome : Allocated to :
If No; give outcome :	Prescription Issued <input type="checkbox"/> Other (give details) <input type="checkbox"/>