GDS Triage Referral Form	
	Date : Time :
Patient Name : Male ☐ Female ☐	
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 ☐ Extirpation ☐ Other ☐ …….
Relevant PMH : Is the patient over 28st (177kilos) YES ☐ NO ☐	
Meds :	
Allergies :	
Has patient been given Advice/Analgesia/Antimicrobials ? YES ☐ NO ☐	Give details and dates :
Are radiographs or photos available and attached ? YES ☐ NO ☐	Give details and dates :
Is the patient in a high risk group for becoming seriously ill ? (see SDCEP document)	YES ☐ NO ☐ Is the patient shielding YES ☐ NO ☐
COVID-19 screen	Does the patient or anyone they live with, have: Cough ☐ Fever ☐ No symptoms ☐
Escort : YES ☐ NO ☐	Does the escort have symptoms of COVID-19 ? YES ☐ NO ☐
Additional Notes :	
<u>Section below for PDS use only</u>	
Receiving Clinician :	Date : Time :
Has the patient to be appointed to clinic ?	YES ☐ NO ☐ If No : Prescription Issued ☐ Other (give details) ☐
If Yes ;	Allocated to : Diagnosis and Tooth : Treatment Provided : Extraction ☐ Extirpation ☐ Specialist Referral ☐ Other (give details) ☐