



SND Specialist
 Dr Hajer Derbi
 Provider Number: 4867926F

Dr. Hajer Derbi
 All Ability Dental
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REFERRAL FORM

The following information is requested for registration, risk assessment and treatment planning.
 If it is incomplete, the patient's dental treatment may need to be delayed until the required information is obtained.

Patient Details			
Name		UR number	
DOB		Gender	
Address			
Tel/Mob		Email	

Referrer details			
Name		Position	
Organisation / Address			
Email / phone / fax			
Date of referral			

Reason for referral (please tick all that apply)	
<input type="checkbox"/> Check-up and preventive care <input type="checkbox"/> Pain, infection, trauma <input type="checkbox"/> Oral hygiene, diet or saliva concerns <input type="checkbox"/> Specific dental problem (tooth, denture, gums) <input type="checkbox"/> Jaw problems or tooth grinding <input type="checkbox"/> Behavioural challenges <input type="checkbox"/> Treatment plan / Care support coordination <input type="checkbox"/> Second opinion / Advice	<input type="checkbox"/> Specific concerns:
Does the patient have any of the following:	Does the patient require completion of dental treatment within a certain timeframe?
<input type="checkbox"/> Inability to provide self-consent - Medical tx decision maker: _____ <input type="checkbox"/> Uncooperative behaviour - Sedation required: yes/no <input type="checkbox"/> Communication aids - Please specify: _____ <input type="checkbox"/> Dysphagia - Modified diet: soft/minced/pureed/no - Thickened fluids: mild/moderate/extremely/no - PEG: yes/no - Nil by mouth: yes/no <input type="checkbox"/> Uncontrolled jaw movements or limited mouth opening <input type="checkbox"/> Needs help with toothbrushing - <input type="checkbox"/> Prompting - <input type="checkbox"/> Modified/electric toothbrush - <input type="checkbox"/> Carer assistance - <input type="checkbox"/> Rejects assistance <input type="checkbox"/> Bed/Wheelchair-bound <input type="checkbox"/> Palliative care needs	<input type="checkbox"/> No <input type="checkbox"/> Yes – please specify:
	Do you require a report from the dentist?
	<input type="checkbox"/> No <input type="checkbox"/> Yes – please specify information required and when it is required by:
	Preferred method of communication: <input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/> Phone <input type="checkbox"/> Consult
	Patient authority to release dental records to a second practitioner
	I hereby give by authority for records regarding my medical/dental treatment to be forwarded to the All Ability Dental team, to whom I have been referred for further consultation and/or course of care.
	Signature: _____ Date: _____

PLEASE ATTACH (where applicable)

- Patient registration form Attached Not available
- Dental history, OPG, intra-oral radiographs (with dates) Attached Not available
- Summary of current and past medical conditions Attached Not available
- Current medication list Attached Not available
- Specialist reports Attached Not available Not applicable

- Advanced care directive Attached Not available Not applicable
- Home oral care plan Attached Not available Not applicable
- Behavioural support plan Attached Not available Not applicable
- NDIS plan Attached Not available Not applicable

FOR DENTAL OFFICE USE:

Further records required

- Osteoporosis Antiresorptive medication history
- Diabetes: HbA1c
- Bleeding disorders: FBE, INR, platelet count, factor levels
- Kidney & liver disorders: U/E, LFTs
- Chemotx/immunosuppressants: FBE
- Radiotherapy: Date, dose, radiation field maps

- Specialist reports: _____
- Allied health reports: _____
- Hospital discharge summary _____
- GA records: _____