Appendix 4

NHS BORDERS PUBLIC DENTAL SERVICE
REQUEST FOR DOMICILIARY ORAL CARE
Send completed request to: bord-uhb.caring4smiles@borders.scot.nhs.uk

Patients Name:

Patients Home Address:

Date of Birth: Tel/Mob number:

Reason for dental request: - Urgent/Routine (Please state)

Does the patient have a denture?

Does the patient have their own natural teeth?

Please provide a brief history and reason for request:-

NB: Please complete full medical history overleaf

Can patient give a valid consent?

Need to discuss, AWIA certificate required (please state)

Is there a financial and/or welfare power of attorney for the patient? Please supply name and daytime contact:-

Does patient receive any benefits? Please state

Not all benefits entitle people to free dental care. If there is a charge an estimate will be given. Patients can complete an HC1/HC1SC to request remission of charges or re-imbursement of cost.

Is the patient able to come into the dental clinic?

Patient will require an escort…

Is patient a wheel chair user?

Does patient need a hoist to transfer?

Referred by (Print)

Position Date

	YES	NO	DETAILS
Do you have any mobility issues or difficulty transferring onto a dental chair?			
Are you taking any medicines from your doctor (tablets, creams, ointments, injections, inhalers, other)?			
Have you taken any medication for osteoperosis or bone disease in the last 3 years?			
Are you currently taking any medication to “thin” your blood?			
Have you had any serious illness?			
Are you taking or have you taken steroids in the last two years?			
Are you allergic to any medicines, foods or materials?			
Have you in the past or are you at present undergoing head or neck radiotherapy?			
Had jaundice, liver, kidney disease or hepatitis?			
Had a heart murmur, heart problem, angina, high blood pressure, heart attack or pacemaker?			
Had any blood tests in the last 12 months?			
Had a bad reaction to a general or local anaesthetic?			
Do you have arthritis?			
Suffer from bronchitis, asthma or other chest condition?			
Have fainting attacks, giddiness, blackouts or epilepsy?			
Have diabetes?			
Bruise easily, or suffered from prolonged bleeding after tooth extraction, surgery or injury?			
Suffer from any infectious disease (including HIV and hepatitis)?			
Have you ever had major surgery?			
Are you expecting a baby or a nursing mother?			
Do you carry a medical warning card?			
Do you regularly drink more than 14 units of alcohol per week?			
Do you smoke or use tobacco, pan, gutkha or supari?			
Are there any other aspects concerning your health that you think the dentist should know about?			
Is there any other information which your dentist might need to know about, such as self-prescribed medicines. (e.g. aspirin, recreational drug use or other drug use)			

Do you weigh less than 21 stone ☐ Weight if over 21 stones ☐

Name and position of person completing the medical history

Is the patient able to consent to care? ☐

If patient unable to consent, please state Welfare Power of Attorney Guardian

For Doctor Responsible: I confirm it is appropriate for this patient to have routine dental treatment, including fillings and extractions, if need be. There are no medical contra-indications or specific precautions needed unless outlined overleaf or in medical history.

Name and designation:

Any queries to Caring for Smiles, Oral Health Promotion, Rushbank, Newstead, Melrose, TD6 9DA 01896 824547/4508 or email: bord-uhb.caring4smiles@borders.scot.nhs.uk