543 DENTAL CENTRE

Reception Name-_____

Date-_____

DOMICILIARY REFERRAL FORM

Patients name- _____

Patients DOB-_____

Patients Address- _____

Post code- _____

Tel No- _____

Senior Carer/Social Worker name- _____

Relatives Name-_____

Relatives Address- _____

Relatives Tel No- House - _____**Mob-** _____

Reason for referral / Treatment need

☐ **Urgent** ☐ **Non-urgent**

PLEASE CALL THE DOMS PHONE IF URGENT – 07415774140

Eligibility Criteria for Domiciliary Oral Healthcare

Does this person go out alone at all? **Yes** **No**

Does the patient attend his/her Doctor?
Yes **No** **Don't know**

If the patient has a hospital appointment, how does he/she get there?
Ambulance **Taxi** **Car** **Other**

Does the patient have someone to bring them to the surgery?
Yes **No** **Don't know**

Does the patient use a taxi for other activities?
Yes **No** **Don't know**

Mobility
Walks unaided **Needs assistance** **Wheelchair user** **Confined to home**

Additional Comments: _____

Does the patient have capacity? Yes ☐ **No** ☐

If the patient does not have capacity, please state why?

_____

_____

Any other relevant information

_____

_____

Reason for Appointment:

Please tick reason for DOM REQUEST

Exam ☐ **Dentures** ☐ **Repair** ☐ **Ease** ☐ **Other** ☐

FOR CARE HOMES ONLY

Is the patient funded by the council? Yes ☐ No ☐
Is the patient partly funded by the council? Yes ☐ No ☐
Is the patient PVT at the nursing home? Yes ☐ No ☐

ONLY FILL THIS IN IF THE PATIENT IS NOT AT A CARE HOME

DO YOU OR YOUR PARTNER RECEIVE PENSION GUARANTEE? Yes ☐ No ☐
DO YOU OR YOUR PARTNER RECEIVE INCOME SUPPORT? Yes ☐ No ☐

HAS THE PATIENT PAID OVER THE PHONE BEFORE THE APPOINTMENT?

Yes ☐ No ☐

If no please explain funds will need to be available on the appointment day.
If payments can be taken over the phone, it will be much appreciated.