SPECIAL NEEDS DENTISTRY
DARTMOUTH GENERAL HOSPITAL

INDIVIDUALS WITH SPECIAL NEEDS DENTISTRY

REFERRAL FORM

Please send completed form to: specialneedsdentistryns@gmail.com

Please ensure all referred patients have been approved for the Individuals with Special Needs Oral Health Program. Application details can be found at:

REFERRING DENTIST INFORMATION

Referring Dentist Name: _____

Office Name & Address: _____

Phone: _____ Email: _____

PATIENT INFORMATION

Patient Full Name: _____

Date of Birth: _____ MSI (Health Card) #: _____

Phone: _____ Email: _____

Mailing Address: _____

PRIMARY CAREGIVER / CONTACT

Full Name: _____ Relationship: _____

Phone: _____ Email: _____

SUBSTITUTE DECISION MAKER (FOR INFORMED CONSENT)

[ ] Same as above

Full Name: _____ Relationship: _____

Phone: _____ Email: _____

CLINICAL ASSESSMENT

Diagnosis qualifying the patient for the Individuals with Special Needs Oral Health Program:

_____

[ ] Receives hygiene treatment at referring office

[ ] Receives hygiene and minor restorative treatment at referring office

[ ] Cannot receive any treatment at referring office

Examination in private practice possible? [ ] Yes [ ] No

Can the patient tolerate radiographs? [ ] Yes [ ] No

Last dental treatment under general anesthesia: [ ] Unknown [ ] Date: _____

Suspected dental needs (check all that apply):

[ ] Multiple extractions [ ] Extensive caries [ ] Urgent infection/pain

[ ] Cleaning/periodontal [ ] Other: _____

Anticipated means of transport to/from hospital: _____

Mobility:

[ ] Ambulatory

[ ] Wheelchair bound - can be transferred to dental chair

[ ] Wheelchair bound - cannot be transferred

Additional Notes/Attachments:

_____

_____

_____

_____