The Royal Dental Hospital of Melbourne

Dental Services Referral Form- Special Needs Clinic

Date	

Title:	Surname	Given name	Date of birth:

Street address	Suburb	Postcode

Name of residential facility (if applicable) **Room:**

Type of residence: ☐ Supported Residential ☐ Shared Supported Accommodation ☐ Residential Aged Care

Level of care: ☐ High ☐ Low

Phone - Home:		Mobile:		Work:	

Country of birth:	

Needs interpreter:	☐ Yes ☐ No	Language:	
Indigenous status:	☐ Neither Aboriginal nor Torres Strait Islander ☐ Not Stated ☐ Aboriginal but not Torres Strait Islander ☐ Both Aboriginal and Torres Strait Islander ☐ Torres Strait Islander but not Aboriginal		

Concession Card type:	☐ Pensioner Concession Card ☐ Health Care Card		
Concession Card No:		Expiry date:	

Next of kin or emergency contact name(s):			
Relationship to patient:		Phone:	
School for under 18 yrs:			

For patients unable to provide self-consent:

Person Responsible name:	☐ Please tick if there is no person responsible		
Relationship to patient (if any):		Phone:	
Address:			

Ability to attend appointments at short notice if available due to vacancies:		
☐ Within 24 hours	☐ Within 1 week	☐ No, require more notice

Once complete please return to:

Patient Services Centre
The Royal Dental Hospital of Melbourne
GPO Box 1273L
Melbourne 3001

Special Needs Clinic : For clinical criteria, exclusions, and patient information – go to page 4

Reason for referral:	Treatment urgency
☐ Examination and treatment ☐ Opinion only ☐ from information provided ☐ from examination of patient	☐ Urgency 1: Suspected malignancy, trauma, medical priority ☐ Urgency 2: Patient experiencing pain ☐ Urgency 3: Routine care

Are you referring this patient to more than one RDHM Clinic?

☐ No
☐ Yes – please specify the other RDHM clinic(s)

☐ Domiciliary Services	☐ Endodontics	☐ Implant
☐ Oral Medicine – Mucosal	☐ Oral Medicine - Facial Pain & TMD	☐ Oral & Maxillofacial Surgery
☐ Orthodontics	☐ Paediatric Dentistry	☐ Periodontics
☐ Prosthodontics - Fixed	☐ Prosthodontics – Removable	☐ Special Needs

Reason for the referral:

Does the patient have any remaining natural teeth? ☐ yes ☐ no

Patient's / Person Responsible's main concern / dental needs (in their own words):

☐ I would like a dental checkup	☐ I want all of my dental problems treated (a complete course of dental care)	☐ I have a toothache
☐ I only want emergency treatment for my main dental concern		☐ I have a problem with my dentures
Other		

Briefly describe how the service requested fits in your overall treatment plan (if applicable).

Summary of medical history: (please attach patient's current full history)

Notable issues	Summary information				Details attached
Physical or sensory impairment	☐ Sight	☐ Hearing	☐ Physical	☐ None known	☐
Intellectual impairment	☐ Learning	☐ Behaviour		☐ None known	☐
Communication Preferred method	☐ Auslan	☐ Non Verbal		☐ Blinking	☐
	☐ Electronic device	☐ Communication Board		☐ None known	
Swallowing problems	☐ Modified diet	☐ Thickened drinks		☐ Supported feeding	☐
Falls Risk / Pressure Ulcers	☐ Falls Risk	☐ Pressure Injuries		☐ None known	☐
Medications	☐ Prescribed	☐ Self administered		☐ None known	☐
Allergies / ADR	☐ Allergies	☐ Adverse Drug Reaction		☐ None known	☐
Other significant risks	☐ Yes	☐ No		☐ None known	☐

Requirements checklist

Additional information required;	**Any recent radiographs** ☐ sent ☐ not applicable **The Domiciliary Services & Special Needs Dentistry Medical Questionnaire (below) must be completed by your medical practitioner. If your medical practitioner can print out a medical summary sheet, please attach this to the Medical Questionnaire.** ☐ sent **Consent provided by the 'Person Responsible' on the Domiciliary & Special Needs Dentistry form (below)** ☐ yes ☐ not applicable
Additional history	**Has the patient been seen by the RDHM Domiciliary service before?** ☐ yes ☐ no **Has the patient been seen by the RDHM Special Needs clinic before?** ☐ yes ☐ no

Screening clinician's notes (RDHM use only):

Referrer details:

☐ Self-Referral ☐ Referral by Person Responsible

☐ Referral by Health Professional. Name: **Phone:**

Please record provider type if applicable.
☐ Dentist ☐ Oral Health Therpaist ☐ Dental Therpaist ☐ Dental Hygienist ☐ Other

Referrer mailing address (if not the same as patient residential or person responsible address)	

Criteria Special Needs Clinic

Appropriate patients	The Special Needs clinic provides a range of dental assessments and treatments to patients with special needs - including physical, intellectual, mental health, complex medical and geriatric issues.
Referral criteria please tick criteria applicable to this patient	**Medically compromised patients who meet one of the following criteria:** ☐ There is a significant risk of a medical emergency ☐ OR there is a significant risk of the proposed treatment adversely impacting the patient's health ☐ AND it is beyond reasonable expectations that the general dental clinic would be able to appropriately manage this patient **Disabilities:** ☐ Severe hearing or visual impairment combined with another condition ☐ Profound intellectual disability ☐ Severe physical disability ☐ Mild to moderate intellectual or physical disability combined with another disability or complex medical condition **People with behavioural problems who meet the following criteria:** ☐ Dental phobic where multiple treatment attempts have failed. ☐ Severe behavioural issue combined with any of the above **Impaired cognitive function:** ☐ Severe impairment combined with another condition Mental health condition ☐ Severe clinical condition, with a written confirmation of a medical practitioner and/or having a case manager ☐ Mental health illness combined with another condition **Patients' living arrangements are also a factor in determining suitability for a referral to the Special Needs Clinic:** ☐ People in Supported Residential Care or Community Residential Units should meet one of the following criteria based on the Residential Classification Scale (RCS): ○ RCS 1-4 plus Mobility C or D ○ RCS 1-4 plus Mobility A or B plus Understanding and Undertaking of Living Activities C or D ○ RCS 5-8 eligible if meeting one of the other criteria in this guideline ☐ Patient within a psychiatric care or mental health facility plus another condition ☐ Homebound patients, where impossible to access any dental facility ☐ Patients with home-based carer plus another condition
Emergency care	Arrangements can be made by calling RDHM Patient Services on (03) 9341 1000 to arrange an emergency appointment either through the Special Needs clinic or Emergency services. Patients with acute symptoms should clearly mark this Dental Services Referral Form as urgent, indicating reasons for urgent attention.
Exclusions	Patients aged 16 years or under should be referred to the Paediatric Dentistry Clinic
Carers	Patients with special needs who have carers assisting them to live at home or in residential care MUST be accompanied by one or more carers at all times. If a patient is unaccompanied at an appointment they may have their treatment deferred until a carer is available
Consent	In situations where the patient cannot provide self-consent or the clinician is not satisfied that the person is capable of providing informed consent, consent needs to be provided by the ***Person Responsible***. If additional examination findings determine that there will be a different treatment plan, these are to be provided in writing or by telephone to the Person Responsible to gain consent for additional or altered dental treatment. See below for the definition of the 'Person Responsible'.
Consultation	Patients meeting the referral criteria will be offered an initial consultation to assess treatment requirements. Patients assessed as needing procedures under general anaesthesia will be placed on the appropriate waiting list. Waiting times are generally shorter for procedures that can be performed under local anaesthesia.

Treatment under general anaesthesia (GA)	Patients referred for treatment under GA are required to attend a dental consultation in the Special Needs Clinic to develop a treatment plan. In special circumstances, if the patient has a severe disability and examination is deemed to be impossible, the Unit Head will consider a direct referral to the Day Surgery Unit (DSU). This can only occur if all relevant information is received i.e medical history Wherever possible copies of any recent radiographs should be provided and/or organised to be taken at the RDHM Radiology Department. If requesting radiographs through RDHM, it is important to note the area or teeth of interest. This will assist Radiology staff to gain the best possible intraoral or extra-oral radiographs. A GA medical questionnaire will need to be completed and returned to Patient Services either by mail or electronically. This will be given to the patient or carer at the consultation appointment for completion or in cases of direct referral to DSU will be organised Once the GA medical questionnaire has been reviewed by the anaesthetist a pre-anaesthetic consultation will be organised. The final determination for a patient's suitability for treatment in DSU is determined at this stage. The anaesthetist will decide if the patient is able to be cared for in the RDHM DSU or whether referral to another medical facility with overnight stay facilities is necessary.

Person Responsible (as defined by the Office of the Public Advocate)	
Definition	The person responsible is the first person, in descending order, on the following list who is reasonably available, and is willing and able to make a medical or dental treatment decision on behalf of the patient:

Examples	• A person who is the patient's medical enduring power of attorney appointed (before the patient became incapable of giving consent) under the Medical Treatment Act 1988;
	• A person appointed by the Victorian Civil and Administrative Tribunal (VCAT) to make decisions about the proposed treatment
	• A person appointed by VCAT to act as a guardian who has the power to make decisions about the proposed treatment
	• A person appointed by the patient (before the patient became incapable of giving consent) as an enduring guardian with the power to make decisions about the proposed treatment
	• A person appointed in writing by the patient to make decisions about medical or dental treatment which includes the proposed treatment
	• The patient's spouse or domestic partner
	• The patient's primary carer, including carer's in receipt of a Centrelink Carer's Payment but **excluding paid carers or service providers;**
	• The patient's nearest relative over the age of 18, which means (in order of preference):
	  ○ Son or daughter
	  ○ Father or mother
	  ○ Brother or sister, including adopted persons and 'step' relationships
	  ○ Grandfather or grandmother
	  ○ Grandson or granddaughter
	  ○ Uncle or aunt
	  ○ Nephew or niece

	The Office of the Public Advocate Fact sheet is also online at http://www.publicadvocate.vic.gov.au/medical-consent/176/

The Royal Dental Hospital of Melbourne

Domiciliary Services & Special Needs Dentistry
Medical Questionnaire

Please print and provide to the patient or Person Responsible for completion and return

Title	Given name	Surname	Date of birth

Consent – by patient or the official 'Person Responsible'

Consent is given for:

- the release of medical history and medication information about the above named person to the Dental Health Services Victoria Domiciliary and Special Needs Dentistry Programs.
- an examination in the first visit, including tooth cleaning, and radiographs where required.

Consent for further treatment will be obtained following the initial examination.

Name: Signature: .....

Consent given by ☐ Patient
☐ Person Responsible Relationship to patient:

Date: / /

Medical history

Please specify past and current medical conditions and hospitalisations (please note any bleeding problems, history of rheumatic fever and prosthetic implants). Please attach another list or Medical History Summary Sheet if available.

Do you normally make house calls for this patient? ☐ Yes ☐ No

Do you consider this patient to be house bound? ☐ Yes ☐ No
If yes, please specify why:

Is there anything else regarding this patient's condition which you feel is relevant to the provision of their dental treatment?
Eg: Dysphagia / swallowing, physical, behavioural problems, communication / comprehension difficulties

Current medication

Please specify current prescription and over the counter medications. You may attach a drug chart photocopy or Webster pack details if necessary.

Does the patient have any drug allergies? ☐ Yes ☐ No

If yes, please specify:

Medical Practitioner details

Medical Practitioner name: Provider Number:

Practice address:

Telephone number:

Signature: ..... Date: / /

Once complete please return to

Patient Services Centre
The Royal Dental Hospital of Melbourne
720 Swanston Street
Carlton
VIC 3053