**URGENT DENTAL CARE TRIAGE AND ONWARD REFERRAL**

To be completed by the referring medic for onward referral of a patient from remote

location into other parts of the Urgent Dental Care system.

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| **Section 1: REMOTE DEANTAL TRIAGE** | | | | | |
| **Date and time called received** | Click here to enter text. | | | | |
| **Caller (patient / parent / carer)** | Click here to enter text. | | | | |
| **Patient Address** | Click here to enter text. | | | | |
| **Patient Postcode** | Click here to enter text. | | | |
| **Contact telephone number(s) for patient** | Click here to enter text. | | | | |
| **Date of birth (dd/mm/yyyy)** | Click here to enter text. | | | | |
| **Gender** | Click here to enter text. | | | | |
| **Location Reference Number** | Click here to enter text. | | | | |
| **Location Detail** | Click here to enter text. | | | | |
| **Contact details of Location Medic** *(including telephone number)* | Click here to enter text. | | | | |
| **Called previously for Dental/Medical Consult (is this a repeat call?)** | | **Yes** | | **No** | |
| **Date of previous call?** | | | Click here to enter text. | | | |

**Continue to next page**

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| **DENTAL TRIAGE** | | | | | | **Please tick to confirm** | |
|  | **CROSS THE BOX MARKED YES OR NO** | | | | | **YES** | **NO** |
| **The patient has been for routine dental check up in the last 12 months?** | | | | |  |  |
| **The patients notes and radiographs (xrays) are attached?** | | | | |  |  |
| **Does the patient have or had a temperature (> 37.8 °C) in the last 14 days?** | | | | |  |  |
| **Does the patient have difficulty in breathing?** | | | | |  |  |
| **Does the patient have difficulty in swallowing?** | | | | |  |  |
| **Does the patient have difficulty in speaking?** | | | | |  |  |
| **Medical History (including allergies, and medication)**  **Social History (Smoking/Vaping/Alcohol Amount/Frequency)** | | | Click here to enter text. | | | | |
| **Presenting complaint** | | | Click here to enter text. | | | | |
| **History of presenting complaint and/or previous treatment:** | | | Click here to enter text. | | | | |
| **PAIN** | | **Where is the pain coming from?**  **How long has pain been there?** | Click here to enter text. | | | | |
| **Severity scale: 1 (no pain) - 10 (worst pain ever)** | Pain Score  (value) | | | *0/10* | |
| **Constant pain / does it come and go?** | Click here to enter text. | | | | |
| **Has it kept you awake / does it get worse at night?** | Click here to enter text. | | | | |
| **Have you taken any painkillers?** | Click here to enter text. | | | | |
| **SWELLING** | | **Intraoral swelling? Size/duration** | Click here to enter text. | | | | |
| **Extraoral swelling? Size/duration** | Click here to enter text. | | | | |
| **Functional impairment caused by swelling (swallowing, breathing and trismus)** | Click here to enter text. | | | | |
| **BLEEDING** | | **Source, duration, amount? Previous bleeding problems (ask about anti-coagulant medications/conditions)** | Click here to enter text. | | | | |
| **TRAUMA** | | **How, Where, What, When?** | Click here to enter text. | | | | |
| **Any loss of consciousness** | Click here to enter text. | | | | |
| **OTHER** | | **Ulcers – location, size, duration?** | Click here to enter text. | | | | |
| **Fractured or broken dental fillings? Fractured teeth?** | Click here to enter text. | | | | |
| **Additional notes** | | | Click here to enter text. | | | | |
| **REMOTE DENTAL CONSULTATION OUTCOME** | | | | | | | |
| **Advice given** | | | Click here to enter text. | | | | |
| **Analgesics advised** | | | Click here to enter text. | | | | |
| **Antimicrobials prescribed** | | | **Name** | Click here to enter text. | | | |
| **Dose** | Click here to enter text. | | | |
| **Duration** | Click here to enter text. | | | |
| **Additional advice** | Click here to enter text. | | | |
| **Prescription number** | Click here to enter text. | | | |
| **Discharge / Complete** | | | Click here to enter text. | | | | |
| **Review / To call back if symptoms deteriorate** | | | Click here to enter text. | | | | |
| **Referral** | | | *MEDIVAC-URGENT* | | Click here to enter text. | | |
|  | | | *DENTIVAC-NON URGENT* | | Click here to enter text. | | |
|  | | | *REVIEW WITH DENTIST* | | Click here to enter text. | | |
| **Radiographs / photographs attached if available** | | | Click here to enter text. | | | | |
| **DENTAL EMERGENCY potentially life-threatening condition** | | | **Advised to communicate directly with relevant medical facility**  Click here to enter text. | | | | |

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| **Medics name** | Click here to enter text. |
| **Medics Reg Number** | Click here to enter text. |
| **Location** | Click here to enter text. |
| **Email** | Click here to enter text. |
| **Telephone number** | Click here to enter text. |