Reset Form

Queensland Government

Metro North Oral Health Service

REFERRAL FORM CHILDREN'S SPECIALIST ORAL HEALTH SERVICES

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Tick as applicable

To	☐ COHS.admin@health.qld.gov.au
Speciality	☐ Paediatric Dental Specialist ☐ Orthodontist
Eligibility	Health Care Care/ Pensioner Concession Card details: ..... Expiry: ..... / ..... / ..... Eligible: ☐ Yes ☐ No Medicare card: ..... Expiry: ...../...../.....
Program Eligibility	☐ Medicare Cleft Lip and Palate Scheme (e.g. Cleft, Oligodontia, etc) ☐ Medically Compromised Patient (e.g. Oncology, Cardiac, etc) .....
Parent/ Guardian/ Agency	Parent/Guardian/Agency name: ..... Relationship to patient: ..... Patent/Guardian/Agency contact number: .....
Child Safety / Consent	Is the child in out of home care? ☐ No ☐ Yes Child Safety Service Centre: ..... Are there any custody or guardianship issues? ☐ Yes ☐ No
Diversity	☐ Interpreter required Preferred Language: ..... ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither ☐ Liaison officer required

Please read the Referral to Specialist Services, Children's Specialist Oral Health Services Procedure prior to referring patients.

Referral details	Category: ☐ Urgent ☐ Non-urgent Reason for referral: ☐ Consult Only ☐ Consultation and Treatment
Background	**History of presenting complaint:**
Medical history	*Current:* *Past:* *Influencing factors:*
Medications	
Allergies	☐ Nil known ☐ known drug or other .....
Imaging	**Recent radiographs are available:** ☐ Yes ☐ No ☐ eUnity ☐ MNHHS InteleConnect (PACS) ☐ Other PACS system .....

REFERRAL FORM CHILDRENS SPECIALIST ORAL HEALTH SERVICES

DO NOT WRITE IN THIS BINDING MARGIN

V1.00 - 11/2024
Locally Printed

Queensland Government

Metro North Oral Health Service

REFERRAL FORM CHILDREN'S SPECIALIST ORAL HEALTH SERVICES

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

ALERTS	Safety alert e.g. aggression / falls risk: ☐ No ☐ Yes Infection Control Alert: ☐ No ☐ Yes Transmission based precautions required: ☐ No ☐ Yes History of Bone Modifying agents ☐ No ☐ Yes Cytotoxic therapy within the last 7 days ☐ No ☐ Yes Requires antibiotic prophylaxis pre dental treatment ☐ No ☐ Yes See Therapeutic guidelines Requires cessation / adjustment of anticoagulation medication prior to dental treatment ☐ No ☐ Yes
Orthodontic Referrals Only	☐ Skeletal Issue Sagittal Issue ☐ Class II Div 1, ☐ Class II Div 2, ☐ Class III Vertical Issue ☐ Deep Bite ☐ Open Bite ☐ Vertical Maxillary Excess Transverse Issue ☐ Skeletal Cross-bite ☐ Asymmetry ☐ Dental Issue ☐ Crowding/Spacing ☐ Anterior Crossbite/Posterior Crossbite ☐ Missing/Supernumerary Teeth ☐ Small/Large Incisors ☐ Impacted Teeth Additional Orthodontic information .....
Sign off	Referring practitioner name *(please print)*: ..... Signature: ..... Date: ... / ... / ... Ward/Clinic/Service: ..... Pager / phone number .....

DO NOT WRITE IN THIS BINDING MARGIN