

**SA Dental
HOMELESSNESS AND ORAL HEALTH PROGRAM REFERRAL FORM**



CLIENT DETAILS

Name.....Date of Birth.....Ph.....

Address.....

Centrelink Concession Card Yes No Card Number.....Exp. Date.....

Important Information About Contacting Client (e.g. privacy issues, custody arrangements, other)
.....

RELEVANT MEDICAL DETAILS

Reported Medical Diagnoses.....

Reported Allergies.....

Reported Current Medications.....

Risks Which May Impact Dental Treatment (e.g. agitation, anxiety, aggression, need for interpreter, other)
.....

REASON FOR DENTAL REFERRAL

URGENT/EMERGENCY <input type="checkbox"/>	NON URGENT/GENERAL <input type="checkbox"/>	If possible, please mark area of concern
Severe current facial swelling <input type="checkbox"/>	Painful tooth, mouth <input type="checkbox"/>	
Trauma to teeth, face, jaw <input type="checkbox"/>	Difficulty eating, sleeping, speaking <input type="checkbox"/>	
Uncontrollable bleeding from the mouth <input type="checkbox"/>	Denture problem <input type="checkbox"/>	
Does the client have:	Lost filling <input type="checkbox"/>	
Own teeth <input type="checkbox"/>	Chipped tooth <input type="checkbox"/>	
Part or full denture <input type="checkbox"/>	Bleeding gums <input type="checkbox"/>	
	Dental check-up <input type="checkbox"/>	

Has the client attended a dental clinic in the last 24 months? If yes, where?.....

In the case of an **urgent/emergency** (as above) during business hours (8:30am - 4:30pm M-F), please ph: (08) 7117 0058 or (08) 7117 0060 as well as emailing referral form to HealthSADSServicePlanning@sa.gov.au. In the case of an after hours **urgent/emergency**, client should attend Emergency Department at the RAH or local hospital.

CONSENT INFORMATION

Consent for dental treatment to be obtained from Client Guardian Other

Name of guardian or other person providing consent.....

To be signed by client (or other person providing consent).....I (name).....consent

to the information on this form being shared with the dental treatment provider

Client/guardian's signature.....Date.....

CLIENT REFERRED BY:

Name.....Referral Agency.....

Phone.....Email.....Signature.....Date.....

EMAIL REFERRAL TO:

SA Dental
Homelessness and Oral Health Program Team
HealthSADSServicePlanning@sa.gov.au
Phone: (08) 7117 0058 or (08) 7117 0060
Fax: (08) 7117 0014

SA DENTAL USE ONLY

Client referred to: CDS
ADH
Private Practice

SA Dental approval number for private practice

1 1 6 7 _ _ _ _ _ Date.....