Domiciliary Dental Service
09:00 – 17:00 Monday to Friday
Unit 10, Sandridge Gate Business Centre
Ronsons Way
St Albans
Hertfordshire
AL4 9XR

Lead Nurse: Stacey Murphy
Tel: 01727 732053
Email:
hct.hertsdentaldoms@nhs.net
Out of hours contact number: 111

NHS Domiciliary Dental Treatment Request Form

Surname/Family Name	**NHS number**	
Forename	**Title**	**Male/Female**
Date of Birth	**Telephone Number**	
Address	**Postcode**	

Details of person completing the form (if on behalf of the patient)	**Details of person who manages patient's finances (bill payer)**
Name	**Name**
Signature	**Relationship to the patient (relative, carer, GDP, GP etc.)**
Relationship to the patient (relative, carer, GDP, GP etc.)	**Contact Number**
Contact Number	**Is the bill payer aware of this referral? Y/N**

ELIGIBILITY

Have you contacted a local dentist? **Yes /No** Do you attend your doctor's surgery? **Yes /No**

If you have a hospital appointment, how do you get there?

Do you have someone to take you to a dental surgery? **Yes /No**

Do you use a taxi for other activities? **Yes /No**

Do you attend a hairdresser or chiropodist? **Yes/No**

Have you had a domiciliary dental visit before? **Yes /No**

REASON FOR DOMICILIARY VISIT

What is the reason for the domiciliary dental visit? Please provide as much information as possible e.g. routine appointment, you are in pain, broken/lost denture

____
____
____

Do you need to be seen urgently? Yes/No
Why do you consider your need is urgent?

When was your last dental appointment?
Was the appointment in a dental surgery or as a domiciliary visit?

PATIENT DECLARATION
I am unable to visit my local dental practice for treatment and therefore request a domiciliary dental visit
Patient's signature ____ Date ____________
(Or relative/carer etc. if patient is unable to sign)

Please give any additional information which will help the dental team.

Are there access difficulties, for example steps? Is parking available/ are there parking restrictions on the street?

Please give details:---

Do you have any communication difficulties? **Yes/No**

If yes please give details---

Do you require the use of a language interpreter? **Yes/No**

Do you have mobility problems or a history of falls? **Yes/No**

Are you confined to bed? **Yes/No**

Do you use a wheelchair ? **Yes/No**

Do you use a mobility aid e.g. a Zimmer frame? **Yes/No**

Please give details of your doctor (Name, Address & Phone Number)

Please provide us with an up to date Medical Summary, plus an up to date list of your medications :-