LUCAS DENTAL CARE

Special Needs Dental Specialist

Dr Nikki Liew
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Patient Details			
Given names		DOB	
Surname		Gender	
Address			
Tel/Mob		Email	

Referrer details			
Name		Position	
Organisation / Address			
Email / phone / fax			
Date of referral			

If the patient is unable to provide their own consent

Medical treatment decision-maker			
Name		Relationship to	
Address			
Tel/Mob		Email	

Reason for referral (tick all that apply)	
☐ Check-up and preventive care ☐ Pain, infection, trauma ☐ Specific dental problem (tooth, denture, gums) ☐ Oral hygiene, diet or saliva concerns ☐ Jaw problems or tooth grinding ☐ Assessment before medical treatment (e.g. surgery, cancer treatment, antiresorptive therapy)	☐ Assessment and reporting for disability supports ☐ Second opinion / Advice Specific concerns:

Does the patient have any of the following:	**Does the patient require completion of dental treatment within a certain timeframe?**
☐ Complex medical history ☐ Physical disability or sensory impairment ☐ Intellectual disability or mental health condition Main diagnoses: _____ _____ ☐ Communication issues: _____ ☐ Challenging behaviours: _____ ☐ Wheelchair-dependent ☐ Swallowing difficulties or difficulty keeping mouth open ☐ May require sedation ☐ Palliative care needs	☐ No ☐ Yes – please specify: **Do you require a report from the dentist?** ☐ No ☐ Yes – please specify information required and when it is required by: Preferred method of communication: ☐ Letter ☐ Email ☐ Phone

PLEASE ATTACH (where possible)

- Dental history notes and Radiographs (with dates)
- Summary of current and past medical conditions
- Current medication list
- Relevant specialist reports