NHS

ENGLAND

Restorative dentistry – Individual Funding Request (IFR) form 2013

For dental referrals of patients registered at GP practices within the Southampton, Hampshire, Isle of Wight, Portsmouth, Bournemouth, Poole and Dorset local authority areas.

*NB patients registered with a Farnham GP practice are outside the responsibility of the Wessex Area Team. Please contact the Surrey & Sussex Area Team regarding dental referrals

Sections 1 to 3 and section 5 are mandatory. Please complete the relevant part of section 4 related to the specialty to which you are referring.

Section one: Please ensure that you answer all of the following questions to enable us to establish the appropriateness of a restorative referral.

	YES	NO
1. Is the patient a regular dental attender over the last 24 months at any practice?	☐	☐
2. Is the patient able to maintain good oral hygiene and maintain any definitive restorations?	☐	☐
3. Is the patient able to open their mouth sufficient to provide treatment?	☐	☐
4. Have alternative treatment options been discussed with the patient?	☐	☐
5. Is the patient willing and able to pay NHS charges for definitive restorations?	☐	☐
6. Has the patient agreed to a specialist referral?	☐	☐
7. Has the initial treatment been completed? (e.g. non-surgical treatment of periodontitis, stabilisation of caries or first attempt of RCT?	☐	☐

If you have answered any of the above questions with a **NO**, the application is likely to be **rejected** as unsuitable for advanced restorative care at this time.

8. Please provide us with the patient's current smoking status.

Smoker ☐ Non-smoker ☐ Ex-smoker for > 6 months ☐

Section Two: General Information

Patient Details

Patient Name:

Patient Date of Birth:

Patient Postcode:

Patient NHS number:

Patient Contact Number:

Patients Registered GP Practice Name and Address:

Current Medication:

Relevant Medical History:

Does the patient have special needs?

Referring Practice Details

Referring Dentists Name:

Dental Practice Name and Address:

Dental Practice Contact Number:

Section Three: Dental History

Teeth Present: (please circle)

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Plaque Score History: Dates	Patient's Plaque Score

Relevant radiographs must accompany all referrals. Please enclose radiographs in an envelope.

Teeth visible on radiograph	Findings

Please describe the long-term impact of this condition on the patient's oral function and/or oral health and why this patient/ condition is exceptional. (Please note that inability to pay for private care is not a criterion for support)

Please outline any previous treatment relevant to this issue including dates of treatment and response achieved.

Please explain why you are unable to manage the patient in your practice.

Please describe the long-term benefits for the patient if this treatment is provided and why this patient will benefit more than might normally be expected for patients with that condition.

Section four: Treatment Requested. Please only complete the section relevant to this patient.

Please complete this section if you are applying for specialist ENDODONTIC treatment on behalf of your patient.

Please explain why the tooth/teeth in question is/are of strategic importance to maintaining oral function and/or health

Who is the patients preferred specialist? (Please ensure that they are on the GDC specialist register) GDC number for specialist:

	YES	NO
Can the tooth/teeth be adequately restored following endodontic treatment?	☐	☐
Does the tooth/teeth have adequate bony support and good long-term periodontal prognosis?	☐	☐
Can the patient tolerate rubber dam?	☐	☐
Would the patient prefer an extraction?	☐	☐

Please complete this section if you are applying for specialist PERIODONTAL treatment on behalf of your patient.

Please provide a description of the periodontal treatment carried out including appointment dates. Treatment completed must include oral hygiene instruction, subgingival debridement of all pockets > 4mm and removal of overhangs, etc before a referral will be accepted.

Treatment Date	Treatment Carried out and Outcome

Please advise us of any mobile teeth , the grade of mobility and BPE scores

Who is the patients preferred specialist? (Please ensure that they are on the GDC specialist register) GDC number for specialist:

Please complete this section if you are applying for specialist PROSTHODONTIC treatment on behalf of your patient.

For **fixed prosthodontics**, please explain why the tooth/teeth in question is/are of strategic importance to maintaining oral function and/or health

For **removable prosthodontics,** please detail any previous attempts to make dentures and issues that may have arisen, e.g. how many denture sets has the patient already worn? What were the previous problems? Are there any predisposing factors, e.g. bony protuberances, resorbed ridges?

Please complete this section if you are applying for DENTAL IMPLANTS on behalf of your patient. *Please ensure that you send a periodontal probing chart along with your application.*

Please describe the long-term impact of this condition on the patient's oral function and/or oral health and why this patient/ condition is exceptional. (Please note that inability to pay for private care is not a criterion for support)

Please describe the long-term benefits for the patient if this treatment is provided and why this patient will benefit more than might normally be expected for patients with that condition.

Please provide us with a full medical history including any indication of any complicating medical factors and medication being taken.

Section 5
Please provide evidence of regular dental attendance over the last 24 months.

Date of appointment	Purpose of visit

Signed

Print

Date