

Residential Aged Care Emergency (RACE) Dental Client Referral Form



CLIENT

Name:		Date of Birth:
RACE CRITERIA Client unable to attend a CDS Clinic because:	Physically dependent <input type="checkbox"/>	Functionally dependent <input type="checkbox"/> Severe Cognitive Impairment <input type="checkbox"/>
Concession Card: PCC <input type="checkbox"/> HCC <input type="checkbox"/>	Card Number:	Card Expiry Date:
Medicare Card	Card Number	Card Expiry Date:
Aboriginal or Torres Strait Islander <input type="checkbox"/>		

CONTACT DETAILS

Client referred by:	Signature:	Position:	Date:
Residential Aged Care Facility:			
Address:			
Ph:	Fax:	Email:	

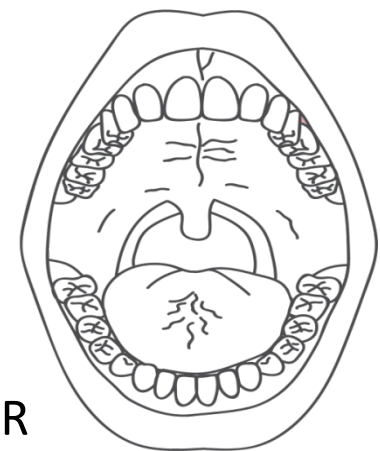
RELEVANT MEDICAL INFORMATION

General Practitioner:	Ph:
Please attach the following:	Y/N
Current Patient Health Summary	
Allergies Latex glove allergy: yes <input type="checkbox"/> no <input type="checkbox"/>	
Current Medications	
Behavioural/Communication information	
Advance Care Planning information	
	Other comments:
	Language spoken:
	Is an interpreter required: yes <input type="checkbox"/> no <input type="checkbox"/>

CONSENT INFORMATION

DETAILS OF WHO:	A. Has agreed to the sharing of client information and to be examined and treated by a dentist.	B. Will arrange payment of client fees for this service. or Same person as in A <input type="checkbox"/>
Name:		
Contact phone number: (mobile number preferred)		
Address:		
Client <input type="checkbox"/> or Substitutue Decision Maker <input type="checkbox"/>		PTO

DENTAL EMERGENCY - identify reason for the referral

RACE 1 – Public Hospital – all RACE clients with a Medicare card	Y/N	If possible mark highlighter pencil (✎) area of concern 
Severe facial swelling		
Uncontrollable bleeding from the mouth		
Significant trauma to face, teeth or jaw		
RACE 2 – SA Dental – only RACE clients with a PCC or HCC	Y/N	
Intra-oral swelling		
Dental pain significantly affecting eating, speaking, sleeping and/or behaviour		
Damaged teeth causing trauma to oral mucosa		
Denture problem significantly affecting eating and/or speaking		
Denture problem causing trauma to oral mucosa		
Suspected oral pathology		

WHO TO CONTACT

RACE 1 – Public Hospital - all RACE clients with a Medicare card

METROPOLITAN

Business Hours:	Hospital	Email	Phone
	Adelaide Dental Hospital: Liaise directly with OMFS RN	Health.SADSOraISurgery@sa.gov.au	8222 8223
After Hours:	Royal Adelaide Hospital: Liaise directly with OMFS Registrar	Completed referral form to go with client to hospital	7074 0000 (Switchboard)

COUNTRY

All Hours: Liaise directly with nearest public hospital emergency service
Send completed referral form to the health service where the emergency care is to be provided

RACE 2 – SA Dental - only RACE clients with a PCC or HCC

METROPOLITAN

Business Hours:	Clinic	Email	Phone
	SNU	Health.SADSADHSpecialNeedsUnit@sa.gov.au	8222 8307

COUNTRY

Business Hours:	Clinic	Email	Phone
	Millicent	HealthSADSMillicent@sa.gov.au	8733 3957
	Mount Gambier	HealthSADSMtGambier@sa.gov.au	8721 1633
	Murray Bridge	HealthSADSMurrayBridge@sa.gov.au	7117 4490
	Naracoorte	HealthSADSNaracoorte@sa.gov.au	8762 2614
	Port Augusta	HealthSADSPortAugustaDentalClinic@sa.gov.au	8668 7840
	Port Lincoln	HealthSADSPortLincoln@sa.gov.au	7669 1700
	Port Pirie	HealthSADSPortPirieCDS@sa.gov.au	8638 4426
	Riverland	HealthSADSRiverland@sa.gov.au	8580 2700
	Walleroo	HealthSADSWalleroo@sa.gov.au	7117 4492
	Whyalla	HealthSADSWhyalla@sa.gov.au	71174493

Record Management:

For SA Dental Use Only: Completed form to be uploaded into the client record