Residential Aged Care Emergency (RACE) Dental Service Client Referral Form

Government of South Australia
SA Health

CLIENT

Name:			**Date of Birth:**
RACE CRITERIA **Client unable to attend a CDS Clinic because:**	**Physically dependent** ☐	**Functionally dependent** ☐	**Severe Cognitive Impairment** ☐
Concession Card: **PCC** ☐ **HCC** ☐	**Card Number:**		**Card Expiry Date:**
Medicare Card	**Card Number**		**Card Expiry Date:**
Aboriginal or Torres Strait Islander ☐			

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**	**Other comments:**
Current Patient Health Summary		
Allergies Latex glove allergy: yes ☐ no ☐		
Current Medications		
Behavioural/Communication information		**Language spoken:**
Advance Care Planning information		**Is an interpreter required:** yes ☐ no ☐

CONSENT INFORMATION

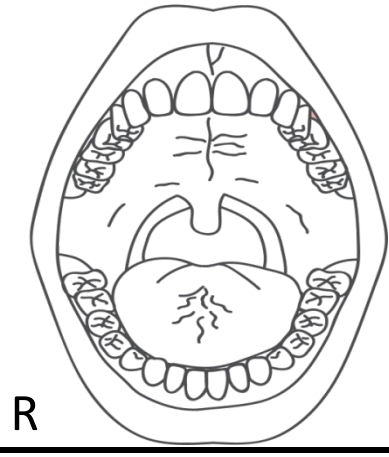
DETAILS OF WHO:	**A.** Has agreed to the **sharing of client information** and to be **examined and treated by a dentist.**	**B.** Will arrange **payment of client fees** for this service. or Same person as in A ☐
Name:		
Contact phone number: (mobile number preferred)		
Address:		
Client ☐ **or Substitue Decision Maker** ☐		**PTO**

DENTAL EMERGENCY - identify reason for the referral

RACE 1 – Public Hospital – all RACE clients with a Medicare card	**Y/N**
Severe facial swelling	
Uncontrollable bleeding from the mouth	
Significant trauma to face, teeth or jaw	

RACE 2 – SA Dental Service – 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	

If possible mark highlighter pencil (✎) area of concern



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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.SADSOralSurgery@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 Service - only RACE clients with a PCC or HCC

METROPOLITAN

Business Hours:	Clinic	Email	Phone
	Special Needs Unit	Health.SADSADHSpecialNeedsUnit@sa.gov.au	82228307

COUNTRY

Business Hours:	Clinic	Email	Phone
	Clare	HealthSADSClare@sa.gov.au	8842 2288
	Millicent	HealthSADSMillicent@sa.gov.au	8733 3957
	Mount Gambier	HealthSADSMtGambier@sa.gov.au	8721 1633
	Murray Bridge	HealthSADSMurrayBridge@sa.gov.au	8531 9300
	Naracoorte	HealthSADSNaracoorte@sa.gov.au	8762 2614
	Port Augusta	HealthSADSPortAugustaDentalClinic@sa.gov.au	8668 7840
	Port Lincoln	HealthSADSPortLincoln@sa.gov.au	8683 2700
	Port Pirie	HealthSADSPortPirieCDS@sa.gov.au	8638 4426
	Riverland	HealthSADSRiverland@sa.gov.au	8580 2700
	Wallaroo	HealthSADSWallaroo@sa.gov.au	8880 5200
	Whyalla	HealthSADSWhyalla@sa.gov.au	8645 1788