# Special Needs Dentistry
**(school based service)**

## Application Form for Dental Examination

### Patient Details

Surname: ..........................................................................................................................
Given Name/s: ..............................................................................................................

- Female ☐  Male ☐

Date of Birth ______ / ______ / ______

Address: ..........................................................................................................................
Postcode: .......................................................................................................................

Telephone number: ......................................................................................................
Mobile: ...........................................................................................................................

Child’s country of birth: .................................................................................................
Mother's country of birth: ..............................................................................................

Language(s) spoken at home: ......................................................................................
Interpreter required? Yes / No

Are you of Aboriginal or Torres Strait Islander origin? Yes / No

Name of child’s school: ..................................................................................................

### Consent Details

Consent is given for (insert patient name) ........................................................................... to receive a dental examination to be provided by a dentist or dental therapist from the Special Needs Dentistry Unit of Dental Health Services Victoria (DHSV).

By providing this consent you have given permission for a dental examination to take place. Following the examination you will be contacted to discuss clinical findings and give consent for any agreed treatment.

Name: ..........................................................................................................................
Signature: ......................................................................................................................

Address: ..........................................................................................................................

Relationship to patient: .......................................................... Date: ______ / ______

### Current Dental Needs

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes / No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would like my child to have a dental check up only</td>
<td>yes / no</td>
<td>I only want emergency treatment for my child’s main dental problem (give details)</td>
</tr>
<tr>
<td>I have particular concerns about my child’s dental health (give details)</td>
<td>yes / no</td>
<td>I want all my child’s dental problems treated (a complete course of dental care)</td>
</tr>
</tbody>
</table>

### Dental History

<table>
<thead>
<tr>
<th>Description</th>
<th>Yes / No</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your child had a dental examination before? (give details: when / where)</td>
<td>yes / no</td>
<td>Has your child attended The Royal Dental Hospital of Melbourne before? (give details: when / why)</td>
</tr>
<tr>
<td>Has your child ever had a general anaesthetic for dental treatment?</td>
<td>yes / no</td>
<td>Has your child ever had problems following dental treatment? (give details)</td>
</tr>
</tbody>
</table>
Medical Questionnaire

Patient's Surname .................................... Given Name ..........................................

Current Medication

Please specify current prescription and over the counter medications:

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........................................................................................................................................
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Drug allergies: yes / no (if yes please describe)

Medical History

As some medical conditions may affect dental care, please complete the following details.

Has your child ever had any of the following medical conditions? Circle yes or no for each condition and if yes, give details.

<table>
<thead>
<tr>
<th>yes</th>
<th>no</th>
<th>Heart disease / heart murmur</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>yes</td>
<td>no</td>
<td>Rheumatic fever</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Epilepsy</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Bleeding requiring medical treatment</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Blood disorders</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Kidney disease</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Asthma or other respiratory diseases</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Liver disease (including hepatitis)</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Allergic or adverse reaction to medicines / other substances (including latex)?</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Has your child ever been a patient in hospital?</td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>no</td>
<td>Does your child have a particular diagnosis</td>
<td></td>
</tr>
</tbody>
</table>

Is there anything else regarding your child that you feel is relevant to the provision of dental treatment? (For example, swallowing problems, physical problems, behavioural problems)

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........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Medical Practitioner Details

Medical Practitioner's name: ..........................................

Address: .............................................................................................

Telephone Number: ...........................................................................

Signature of Parent / Guardian: ......................................................... Date: .......... / ........... / ...........

Thank you for completing this questionnaire. If you have any questions, please contact us on 9341 1261.