

Community Dental Service

Referral Portal Guide

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About the Referral Portal

The Referral Portal allow referrers to send referrals to your service directly. Your community dental provider will provide you with a link to the portal or a button will be available on their website.

The link for your Whittington Community Dental Service referral portal is as follows:

<https://ewnd.sfd.co/referral>

The referral portal will offer the ability to create an account, fill out and submit your referral, then track the referral you have submitted.

How do I create a referrer account?

Referrals will only be accepted by the service if you register with a secure email address from NHS.mail or Gov email account. You will need to have access to the email account that you submit your referral under. You will also need to provide **your mobile number for multifactor authentication.**

Visit the portal site using the following link <https://ewnd.sfd.co/referral> or via our dental webpage on the main Whittington Website – **link to this will follow (currently under review)**



Select **Register** to create an account.

Details	
Email	Address
<input type="text"/>	<input type="text"/>
Surname	
<input type="text"/>	
Forename	City
<input type="text"/>	<input type="text"/>
Mobile	County
<input type="text"/>	<input type="text"/>
Job Title	Postcode
<input type="text"/>	<input type="text"/>
Role	Secure Email
<input type="text" value="Dental professional"/>	<input type="text"/>
Back	Save

Enter your details. Please include all details. Your email address is required, as you will be required to use your email address to log back into the referral portal. Secure email is also required, this will be used for communicating any patient updates

Details

Email

Address

Surname

City

Forename

County

Mobile

Postcode

Job Title

Secure Email

Role

Dental professional

Back

Save

Click **Save** to register your account.

Settings

Sign out

Once logged in, you have the ability to change your details by selecting the **Settings** button at the bottom of the screen.

How do I refer a patient?

Log in to the referral portal, as shown in the previous section. Once logged in you will have access to the available referral forms.

Please select referral form below

HOMELESS PROJECT NCL 2025
BARNET-HARINGEY-ENFIELD
ONLY

LONDON INTERMEDIATE
MINOR ORAL SURGERY
REFERRAL FORM

PAEDIATRIC DENTISTRY
REFERRAL FORM (CHILDREN 15
YEARS OLD AND YOUNGER)



SPECIAL CARE DENTISTRY
REFERRAL FORM (16 YEARS
OLD AND ABOVE)

Select the required referral form by clicking the name of the form.


NHS England

PAEDIATRIC DENTISTRY REFERRAL FORM (CHILDREN 15 YEARS OLD AND YOUNGER)

Surname: <input type="text"/>		Forename: <input type="text"/>		Sex: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other
Date of Birth: <input type="text" value="dd/mm/yyyy"/>	Title: <input type="text"/>	NHS Number: (if known) <input type="text"/>		<input type="checkbox"/> Looked after child
Interpreter required: <input type="text"/>		Contact email address: <input type="text"/>		<input checked="" type="checkbox"/> Email to parent / guardian

Home: Address: <input type="text"/> City: <input type="text"/> Post Code: <input type="text"/>  Phone: <input type="text"/> Mobile: <input type="text"/>	GP: Address: <input type="text"/> City: <input type="text"/> Post Code: <input type="text"/> 
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Referrer

Name: <input type="text" value="Dr Tooth White"/>	Role: <input type="text" value="Dental Professional"/>
Address: <input type="text" value="Dental Practice"/> <input type="text" value="Dentist Road"/>	Job title: <input type="text" value="Dentist"/>
City: <input type="text" value="London"/>	Secure Email: <input type="text" value="Info@dentalpractice.nhs.net"/>
Post Code: <input type="text" value="LD34 6YT"/> 	

Priority


☐ A Severe dental trauma with no/minimal initial management (This is not an immediate trauma service, please also direct the child to a trauma service via 111)
☐ B Severe dental trauma which has already had appropriate initial management (e.g. a resorbed or resorbed trauma service)

☐ D First episode of facial swelling or repeated episodes not witnessed by a dental care professional
☐ D Pain or infection with loss of sleep or days off school but no facial swelling
☐ D Aged 10 or approaching the end of their treatment window with poor prognosis molars

Your personal details as the referrer will be automatically added to the form. Fill out the referral form as required.

The forms available will vary but each form comprises of text boxes, check box, drop down options and allows you to upload images if required.

You will notice on the form that the address can be looked up by selecting the Postcode button next to the postcode field. Once selected this will auto fill the address fields. You can still manually enter the address if required.

Post Code: 

The form will change and expand depending on the options selected on the form.

See example below:

Does the patient have any relevant medical history / medication / allergies?

Additional Behavioural Needs (ABN)

Does the patient have any relevant medical history / medication / allergies?

Medical History:	Medication:	Allergies:
<input type="text"/>	<input type="text"/>	<input type="text"/>

☐ Patient under hospital care for a medical reason, and if so which?

Additional Behavioural Needs (ABN)

Parts of the form are mandatory. This is indicated on the form with fields marked with an Asterix.

When you have completed the referral form the Submit button is located at the bottom of the form

THIS REFERRAL WILL NOT BE ACCEPTED WITHOUT COMPLETION OF ALL RELEVANT SECTIONS

Submit
Back

Click **Submit**.


Note: If your form does not submit the form will indicate the mandatory fields that have been missed. Please fill the fields and submit again.

How do I review my submitted referral.

Once the referral has been submitted to the Community Dental Service, you are able to view the status of the referral within the Referral Portal.

Login to the portal as shown in section 1.

Within the Portal you will see the referral forms that you have submitted.



Please select referral form below

HOMELESS PROJECT NCL 2025
BARNET-HARINGEY-ENFIELD
ONLY

LONDON INTERMEDIATE
MINOR ORAL SURGERY
REFERRAL FORM

PAEDIATRIC DENTISTRY
REFERRAL FORM (CHILDREN 15
YEARS OLD AND YOUNGER)

SPECIAL CARE DENTISTRY
REFERRAL FORM (16 YEARS
OLD AND ABOVE)

ID	DateTime	Type	Name	Status	
255	15/09/2025 14:01		JAMES, Test1	Submitted	📄
254	15/09/2025 14:01		JAMES, Test1	Submitted	📄
253	15/09/2025 14:01		JAMES, Test1	Submitted	📄
179	04/09/2025 14:15		VERNON, Adam	Pending	📄
176	29/08/2025 10:57		SFD, TEST	Pending	📄
119	18/06/2025 10:26		SMITH, John	Discharged	📄
118	16/06/2025 09:39		RANNS, Maddison	Discharged	📄

Showing 1 to 7 of 7 rows

When the referral is submitted it will automatically be placed on a waiting list as 'Submitted'.

Note: It is important to note that this does not indicate that the referral will be accepted. Each patient will still undergo a triage process as per the Community Dental Service policy and process.

You are able to view the status of the referral within the Portal. The Status is shown next to each referral and will automatically update as the patient moves through their referral Journey.

To view your submitted referral form, select the PDF icon next to the referral



Once the button is clicked a PDF view of your submitted form is displayed.

Whittington Health **NHS**

PAEDIATRIC DENTISTRY REFERRAL FORM (CHILDREN 15 YEARS OLD AND YOUNGER)

Surname: [Text] **Forename:** [Text] **Sex:** ☒ Male ☐ Female

Date of Birth: [Text] **Title:** [Text] **NHS Number: (if known):** [Text]

Interpreter required: [Text] **Contact email address:** [Text] ☒ Email to parent / guardian

Home: [Text] **GP:** [Text] **Referrer:** [Text]

Address: [Text] **City:** [Text] **Post Code:** [Text] **Phone:** [Text] **Mobile:** [Text]

GP: [Text] **Address:** [Text] **City:** [Text] **Post Code:** [Text]

Referrer: [Text] **Job title:** [Text] **Secure Email:** [Text]

Priority: ☒ A Severe dental trauma with no/minimal initial management (This is not an immediate trauma service, please also direct the child to a trauma service via 111) ☐ B First episode of facial swelling or repeated episodes not witnessed by a dental care professional ☐ C Pain or infection with loss of sleep or days off school but no facial swelling ☐ D Severe dental trauma which has already had

Click back at the bottom of the PDF View to return to the Portal referral list.

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