Practice Plus Group

Oral Surgery referral form

Please complete in block capitals or digitally. Please note, we no longer accept referral forms by fax. Please send this form by email to dentalreferrals.egd@nhs.net

Which centre are you referring the patient to?

☐ Practice Plus Group Hospital, Emersons Green
☐ Practice Plus Group Surgical Centre, Devizes

Referrer details

Date of referral	
Referring practitioner	
GDC number	
Dental practice name	
Practice address	
Telephone	
Fax	
Email address	

Please complete

Name of patient's GP	
Name of GP Practice	

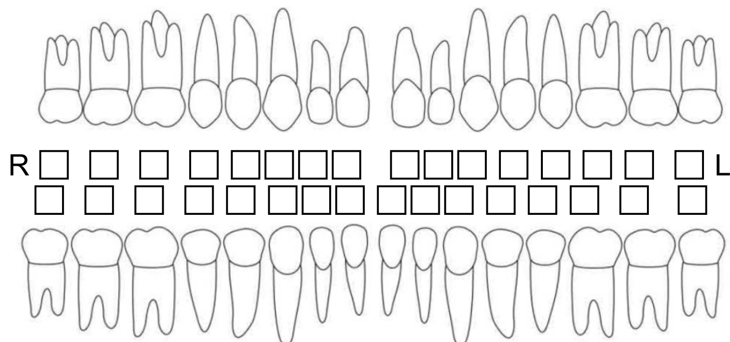
Patient details

Name		
NHS No		
Address		
Post code		
Telephone		
Mobile		
Date of Birth		
Gender / ethnicity	Drop down	Drop down
Height / weight		
Interpreter requirements		

If wisdom tooth removal requested please confirm NICE guidelines have been adhered to: Yes ☐ No ☐

Treatment requested, with diagnosis, and details of consideration of other treatment options

Please indication on the chart below the tooth / teeth to which the requested procedure refers:



All medical conditions **(if extensive please continue on separate sheet)**

Patient's current medication

Known allergies

Details of future treatment plans or provision of dental care, e.g. do you intend to restore other decayed teeth, provide dentures or other ongoing preventative and restorative care?

Radiographs

To adequately assess the referral we must request that all relevant radiographs are included. Digital images should be printed on high quality photographic paper or emailed to **referrals.careukagw@nhs.net** to ensure no loss of diagnostic quality.

Please indicate if you require the return of radiographs when treatment is complete.

Radiographs included? Yes ☐ No ☐

If yes, please state type of exposure and date taken

Has Practice Plus Group exclusion criteria have been adhered to:
Yes ☒ No ☐

These are available at:
www.emersonsgreenhospital.co.uk/information-for-referrers
www.devizessurgicalcentre.co.uk/information-for-referrers

Referrer name	
Referrer signature	
Date	