

GENERAL ORAL SURGERY Referral form May 2022



Head and Neck Suspected Cancer referrals must be submitted via the Fast Track Office to tertiary centres, either via

Choose & Book (preferred method) or Email 2 Week Wait form can be downloaded at

<https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/>

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.careukegd@nhs.net

Which centre are you referring the patient to?
 Practice Plus Group Hospital, Emersons Green
 Practice Plus Group Surgical Centre, Devizes

PATIENT DETAILS

Surname: First name: Date of Birth:

REFERRAL INFORMATION

FULL PATIENT DETAILS	REFERRER DETAILS
Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> NHS Number: Surname: First name: Date of Birth: Address: Town/City: Postcode: Telephone Number: Mobile Number: E-mail Address:	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Other <input type="checkbox"/> Surname: First name: Job Title: GDC/GMC Number: Practice Name: Practice Address: Town/City: Postcode: Telephone Number: E-mail Address:

REASON FOR REFERRAL/CLINICAL DETAILS. Please detail reason for referral and what you want us to do for your patient.

Please refer to referral guidelines:
<https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/04/mcn-oral-surgery-referral-guidelines-for-gdps-Feb-2022V1-002.docx>

TREATMENT REQUESTED

Extraction Cyst enucleation
 Consider Coronectomy

Is this patient suitable to accept treatment under LOCAL ANAESTHETIC?
 YES NO If no, reason why

If considering sedation, what is the justification for this:

WE DO NOT OFFER TREATMENT UNDER GENERAL ANAESTHETIC

RADIOGRAPHS

RADIOGRAPHS are required for patient assessment. If tooth is fully erupted a diagnostically acceptable radiograph is required. If tooth is partially erupted, a radiograph which justifies referral will be accepted (e.g. caries demonstrated in lower 7.)

Tick this box to confirm diagnostically acceptable radiograph sent with referral.

DPT Intra Orals None (reason required)

MEDICAL HISTORY

Please attach up-to-date medical history for all referrals – referrals will be returned if this is not included

Medical Conditions: Tick box 1 if none. Complete if other

1.No Relevant Medical History confirmed

Current Medication:

***Bisphosphonates/Denusemab state no. of years.....**

2. Weight (250kg /39 stone maximum for our facilities)

3. BMI if considering sedation (42 maximum)

Allergies: No Yes Provide details

Tick ALL relevant boxes and provide full details

- Warfarin
- DOACs e.g. rivaroxaban
- Aspirin/Clopidogrel
- Bleeding disorders (not routinely treated by PPG)
- Bisphosphonates (oral)*
- Bisphosphonates (IV)*
- Denusemab*
- DMARDS (Drugs for rheumatoid conditions)
- Oral Steroids
- Diabetes
- Cardiac Valve replacement or hx endocarditis
- Immunosuppressant's
- Chemotherapy
- Sleep Apnoea CPAP (no sedation provision)

OTHER INFORMATION (E.g. Living arrangements, Legal guardian, Interpreter required)

PATIENT GP DETAILS (if not the referrer)

Mr Mrs Miss Ms Dr Other

Surname:

First name:

Practice Name:

Practice Address:

Town/City:

Postcode:

Telephone Number:

E-mail Address:

COMMUNICATION & SPECIAL REQUIREMENTS

Does the patient communicate in a language or mode other than English?

YES , please detail. NO

Is an interpreter required?

YES , please detail. NO

Does the patient have any special requirements?

YES , please detail. NO

PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT

Has the patient understood and consented to the referral? YES NO

CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER

I confirm that this patient referral meets the current referral guidelines as issued by the Southwest LDN. (Referral guidelines are available on the LDN website). I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Please note that it is now a mandatory requirement for referrers to provide their GDC or GMC Number on this form Please tick to confirm.

Print Full Name:..... **Date:**.....

Signature:

Details of returning this to your local provider can be found at Appendix 4, page 21 (see below)

Relevant information for Details of Oral Surgery Providers for the Southwest Region can be found on the Oral Surgery Referral Guidance Document 2022 Appendix 4 page 21.

<https://www.england.nhs.uk/south/info-professional/dental/dcis/south-west>