GENERAL ORAL SURGERY Referral form January 2024

Practice Plus Group

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.egd@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 ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐
Male ☐ Female ☐ NHS Number:	Surname:
Surname:	First name:
First name:	Job Title:
Date of Birth:	GDC/GMC Number:
Address:	Practice Name:
Town/City:	Practice Address:
Postcode:	
Telephone Number:	Town/City:
Mobile Number:	Postcode:
E-mail Address:	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 also note any further treatment planned for the patient (e.g. if there are other teeth of questionable prognosis/dentures etc)

Please refer to referral guidelines on our website and
https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/

TREATMENT REQUESTED (written and charted)

☐ **Extraction of:**

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

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RADIOGRAPHS

RADIOGRAPHS of all teeth to be extracted 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 include full 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 ☐

Or medical history:

Current Medication:
***Bisphosponates/Denusumab state no. of years……..**

2. BMI (42 maximum for sedation, 45 for LA):

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)*
- ☐ Denusumab*
- ☐ 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 pg 21.
https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/