ORAL AND MAXILLOFACIAL SURGERY

ROUTINE PROFORMA FOR REFERRAL TO MINOR ORAL SURGERY OR HOSPITAL

NOT to be used for referrals to emergency care, urgent care or the Community Dental Service

Referring General Dental Practitioner Name: Address: E-mail address (nhs.net only) : Tel: Fax:	Patient's GP details Name: Practice: Address:
Patient's details IN BLOCK CAPITALS please Name: Male/Female ☐ ☐ Address: Postcode **(ESSENTIAL)** **Dob:** Tel: (Daytime): (Mobile): NHS number (if known)	Relevant medical history ☐ yes ☐ no If yes, please provide details:

1. Dental extraction(s):- You must tick one or more reason(s) below, AND provide additional information including the clinical reasoning for the extraction in section 5.

- ☐ Failed attempt by GDP
- ☐ Poor access to tooth due to limited opening
- ☐ Complex retained roots within bone
- ☐ Abnormal tooth morphology including fused teeth and severely angled or bulbous roots.
- ☐ Teeth with periapical areas >1cm or evidence of cystic change.
- ☐ Teeth with unexplained root resorption
- ☐ Patients with complex medical histories conforming to referral guidelines (includes warfarin, steroid and bisphosphonate guidance)
- ☐ Unerrupted or impacted teeth (this includes Wisdom teeth conforming to NICE guidelines).

Teeth to be extracted (please circle or 'check' box if completing electronically)

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Please enclose an appropriate radiograph of diagnostic quality showing the tooth/teeth including the whole root to be extracted (digital radiographs should be clearly printed or sent electronically).

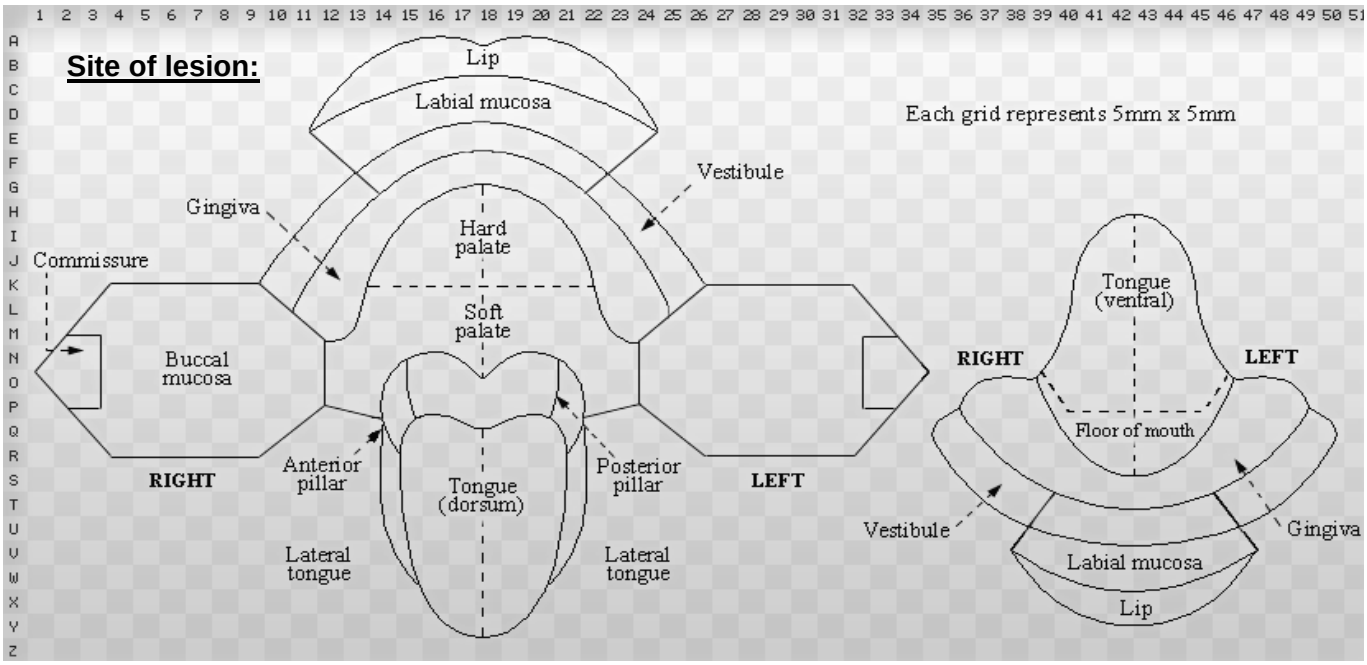
2. Apicectomy:- ***Please see referral guidelines for apicectomies that will be accepted***

Tooth to be apicected: ----------

Please enclose an appropriate radiograph of diagnostic quality showing the tooth to be apicected (digital radiographs should be clearly printed or sent electronically)

3. Non-urgent oral lesions and biopsy:- ***If completing electronically, please add grid reference for site of lesion***

Details of lesion:



4) Other conditions: ***it is essential you tick at least one reason and provide details in section 5.***

- ☐ Soft tissue surgery, including: fraenectomy and release of tongue-tie, removal of fibro-epithelial polyps, mucoceles, and uncomplicated denture induced mucosal hyperplasia.
- ☐ Salivary gland problems, including xerostomia.
- ☐ Persistent oro-antral fistula.
- ☐ Non-urgent dental radiolucencies and opacities.
- ☐ Alveolar ridge trimming.
- ☐ Advice only.
- ☐ Sinus problems.
- ☐ Orthodontic care with a surgical element, including exposure of teeth. (Note, orthodontic extractions are not accepted, unless they conform to the tooth extraction guidelines –see over).
- ☐ Complications of facial trauma.
- ☐ Cleft lip/palate.
- ☐ Facial pain.
- ☐ Tempero-mandibular problems.
- ☐ Other

5. Additional relevant information (MUST be completed or referral will not be accepted): - ***reason for extractions, including history of complaint, communication problems etc***

Please send the completed proforma to: Primary Care Booking Office 1st Floor, 11 Station Road, Maidstone, Kent, ME14 1QH wk-pct.kmomfs-rts@nhs.net

Electronic referrals must be sent to and from secure nhs.net accounts only, for data protection
If nhs.net unavailable, please send by post.

If this referral is incomplete, does not have appropriate x-rays, completed medical history or conform to the guidelines , it will be returned

For official use only: Return to referrer ☐ IMOS Service ☐ Secondary Care ☐ Version – 06.07.12