sss

Somerset Surgical Services,

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**SSS Oral & Maxillofacial Surgery Referral Form**

**\*Local Anaesthetic Service Only\***

To help with efficient processing of referrals please ensure that **all** sections are completed accurately. If any information is missing or incorrect the referral will be returned.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** |  | | **First Name** | |  | | | **Surname** | |  | | |
| **DOB** |  | | | **NHS No** | |  | | **Gender** | | | Male | Female |
| **Address and**  **Postcode** | |  | | | | | | | | | | |
| **Home telephone** | |  | | | | | **Mobile number:** | |  | | | |
| Is the above address a temporary address? Yes  No  If yes, please give details at the bottom of the next page | | | | | | | | | | | | |
| I confirm that the patient is ready, willing and able to attend their appointment | | | | | | | | | | | | |

|  |  |
| --- | --- |
| **GP Surgery:** |  |

Unfortunately SSS cannot accept patients who are not registered with a GP

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please ensure that the reason meets secondary care requirements. We cannot accept referrals without a reason listed below.  **Please list reason for referral and expected outcome here:**  **Please confirm and mark below the tooth/teeth/root being referred:**   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **UR** | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | **UL** | | **LR** | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | **LL** |   Please note that any patient who DNAs their appointment will be discharged back to their dental surgery. |
| **All referrals must be accompanied by radiology images. Please include one of the following:**  OPG  Occlusal  Periapical  Bitewing   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Referrer name:** |  | **Telephone:** |  | | | **Practice Name & address** |  | | |   **Signed: Dated:** |

**Confidential Medical History – Please tick Yes/No giving any relevant details**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No** | **Yes** | **Details** |
| Does the patient require any additional help with their appointments? |  |  |  |
| Does the patient need an interpreter?  *If yes please state which language* |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Has the patient ever had a general anaesthetic?  If YES, where, when and what for. |  |  |  |
| Has the patient taken drugs or medicines during the past 12 months?  If YES, please give drug name. |  |  |  |
| Is the patient allergic to Penicillin or any other drugs or medicines?  If YES, please give drug name. |  |  |  |

Has the patient suffered from any of the following? Please give details:

|  |  |  |  |
| --- | --- | --- | --- |
| Heart conditions |  |  |  |
| Diabetes |  |  |  |
| Allergies e.g. hayfever |  |  |  |
| Fits or convulsions |  |  |  |
| Fainting or Blackouts |  |  |  |
| Bleeding problems |  |  |  |
| Jaundice |  |  |  |
| Asthma, bronchitis or any other chest complaint |  |  |  |
| Any other serious illness  If YES, please specify. |  |  |  |
| Does the patient smoke? |  |  |  |
| Is the patient pregnant?  *Please ensure patients are aware treatment may be delayed until after pregnancy.* |  |  |  |
| Please state any other relevant past medical history: | | | |
| Any other additional comments or information helpful to Somerset Surgical Services: | | | | |