

Somerset Surgical Services,

Weston General Hospital,

Grange Road, Uphill,

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BS23 4TQ

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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 illnessIf 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: |