**BRISTOL DENTAL HOSPITAL – REFERRAL FORM**

**APICAL SURGERY**

**Head and Neck Suspected Cancer referrals must be submitted via the Fast Track Office, either via Choose & Book (preferred method) or Email** **ubh-tr.fast-trackreferrals@nhs.net** **2 Week Wait form can be downloaded at** [**https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/**](https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/)

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| **PATIENT DETAILS** |
| **Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….………** |
| **SECTION 1 - REFERRAL INFORMATION** |
| **URGENT** [ ]  **ROUTINE** [ ]  *(please tick)* |
| **SECTION 2 - TRIAGE INFORMATION** |
| **BDH USE ONLY** | **ROUTINE** |  | **UPGRADE TO FAST TRACK** |  |  |
| **URGENT** |  | **WITHIN 1 WEEK** |  | **WITHIN 2 WEEKS** |  |
| **DATE TRIAGED** |  |
| **PRINT NAME** |  |
| **REASON FOR REFERRAL/CLINICAL DETAILS.**  Please detail reason for referral and what you want us to do for your patient.Guidance on assessing suitability for apical surgery: http://www.rcseng.ac.uk/fds/publications-clinical-guidelines/clinical\_guidelines/documents/surgical\_endodontics\_2012.pdf |
| TOOTH OF CONCERN  | REASON FOR REFERRAL [ ]  Continued on separate sheet/ letter attached [ ]  Pain[ ]  Swelling[ ]  Sinus[ ]  Incidental radiographic findingPlease comment:………………………………………………………………………………… |
| HAS THE TOOTH/ TEETH BEEN ROOT TREATED AT LEAST TWICE? YES [ ]  NO [ ] If NO state reason …………………………………………………………………..Is this a functional tooth, or is there the potential for it to be in occlusion? YES [ ]  NO [ ]  |
| WHAT CORONAL RESTORATION IS PRESENT?Crown [ ]  Post Crown [ ]  Plastic filling [ ] If so – any history of decementation? YES [ ]  NO [ ] Is this restoration sound? YES [ ]  NO [ ]  | PERIODONTAL CONDITIONOral Hygiene: Good [ ]  Fair [ ]  Poor [ ]  |
| **INTRA-ORAL EXAMINATION** | Tooth requiring apicectomy | Adjacent mesial tooth | Adjacent distal tooth |
| Vitality test results |  |  |  |
| Tenderness to tap (TTT) |  |  |  |
| Mobility grading (1, 2 or 3) |  |  |  |
| 6 point perio chart |

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 | **X** | **X** |
| **RADIOGRAPHS** |
| RADIOGRAPHS are required for patient assessment. A **diagnostically acceptable** radiograph is required as a minimum. At least 3mm beyond the root apex must be seen,[ ]  Tick this box to confirm **diagnostically acceptable** radiograph sent with referral. DPT [ ]  Intra Orals [ ]  None (reason required) [ ]  …………………………………………………………………………..Return radiographs on completion of treatment? Yes [ ]  |
| **SECTION 3 - ADDITIONAL INFORMATION** |
| **MEDICAL HISTORY -** Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history as needed. **YES** [ ] , please detail. **NONE** [ ]  |
| **MEDICATION -** Please state type and dosage details. **YES** [ ] , please detail. **NONE** [ ]  |
| **ALLERGIES -** Please state allergy and description of reaction, if known. **YES** [ ] , please detail. **NONE** [ ]  |
| **OTHER INFORMATION** (E.g. Living arrangements, Legal guardian) |
| **SECTION 4 – FULL PATIENT DETAILS** | SECTION 5 - REFERRER DETAILS |
| **Mr** [ ]  **Mrs** [ ]  **Miss** [ ]  **Ms** [ ]  **Dr** [ ]  **Other** [ ] **Male** [ ]  **Female** [ ]  **NHS Number:****Surname:****First name:****Date of Birth:****Address:****Town/City:****Postcode:****Telephone Number:****Mobile Number:****E-mail Address:** | **Mr** [ ]  **Mrs** [ ]  **Miss** [ ]  **Ms** [ ]  **Dr** [ ]  **Other** [ ] **Surname:****First name:****Job Title:****GDC/GMC Number:****Practice Name:****Practice Address:****Town/City:****Postcode:****Telephone Number:****E-mail Address:** |
| SECTION 6 - PATIENT GP DETAILS ***(if not the referrer)*** | SECTION 7 - COMMUNICATION & SPECIAL REQUIREMENTS |
| **Mr** [ ]  **Mrs** [ ]  **Miss** [ ]  **Ms** [ ]  **Dr** [ ]  **Other** [ ] **Surname:****First name:****Practice Name:****Practice Address:****Town/City:****Postcode:****Telephone Number:** | **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** [ ]  |
| **SECTION 8 - 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 [ ]  |
| **SECTION 9 - PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** |
| Has the patient understood and consented to the referral? YES [ ]  NO [ ]  |
| **SECTION 10 – CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER** |
| I confirm that this patient referral meets the current referral guidelines as issued by the Bristol Dental Hospital. (Referral guidelines are available on the BDH website). I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Please tick to confirm. [ ]  |
| **Print Full Name:………………………………………………………………………………………………… Date:………………………….................****Signature: ………………………………………………………………………………** |

**Please return fully completed forms to: Patient Access Team, Bristol Dental Hospital, Chapter House, Lower Maudlin Street, Bristol, BS1 2LY. Email** ubh-tr.uhbristoloralsurgeryreferrals@nhs.net **Call Centre Tel: 0117 342 4422.**