**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**](mailto: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/)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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.    **Please refer to referral guidelines** [**http://www.uhbristol.nhs.uk/media/2483177/uh\_bristol\_dental\_information\_pack\_and\_referral\_guidelines\_pack\_final\_9\_jan\_15.pdf**](http://www.uhbristol.nhs.uk/media/2483177/uh_bristol_dental_information_pack_and_referral_guidelines_pack_final_9_jan_15.pdf) **v** | | | | | | | |
| **TREATMENT REQUESTED**  (for Apical Surgery and Wisdom tooth removal please use specific forms)  Extraction  Exposure & Bonding  Biopsy  Other (please specify) | | | | | | | |
| Is this patient suitable to accept treatment under LOCAL ANAESTHETIC? If so, this may help to expedite the waiting time for treatment for your patient. YES  NO  If no, reason why ……………………………………………………………………………………. | | | | | | | |
| **RADIOGRAPHS** | | | | | | | |
| RADIOGRAPHS 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)  …………………………………………………………………………..  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:**  **E-mail Address:** | | | | | **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 - PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** | | | | | | | |
| Has the patient understood and consented to the referral? YES  NO | | | | | | | |
| **SECTION 9 – 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 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: ………………………………………………………………………………** | | | | | | | |

**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](mailto:ubh-tr.uhbristoloralsurgeryreferrals@nhs.netC) **Call Centre Tel: 0117 342 4422.**