**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.**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 **Call Centre Tel: 0117 342 4422.**