**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. | | | | | | | | | | | |
| Tooth to be removed | | | | | UR8 | | UL8 | | | LR8 | LL8 |
| Second or subsequent episodes of Pericoronitis | | | | |  | |  | | |  |  |
| Unrestorable caries in tooth/ adjacent teeth | | | | |  | |  | | |  |  |
| Untreatable pulpal or periapical pathology | | | | |  | |  | | |  |  |
| Abscess | | | | |  | |  | | |  |  |
| Root resorption in tooth/ adjacent teeth | | | | |  | |  | | |  |  |
| Fracture of tooth | | | | |  | |  | | |  |  |
| Cyst | | | | |  | |  | | |  |  |
| Periodontal disease affecting tooth/ adjacent teeth | | | | |  | |  | | |  |  |
| Tooth causing traumatic occlusion | | | | |  | |  | | |  |  |
| Previous attempted extraction | | | | |  | |  | | |  |  |
| Other - please specify | | | | |  | |  | | |  |  |
| **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.**