**FORM A**

**Referrals for Primary Care DwSI Minor Oral Surgery**

**and Hospital Oral and Maxillofacial Surgery**

**DO NOT USE FOR FAST TRACK CANCER REFERRALS**

*Please return to the Referral Management Centre. For address see overleaf at end of form*

**Please complete all sections or the form will be returned. See Referral Guidelines**

[www.sompar.nhs.uk/dental/referrals-somerset](file:///C:\Users\eva.gauterin\AppData\Local\Microsoft\Windows\Temporary%20Internet%20Files\Content.Outlook\MELSEDJP\www.sompar.nhs.uk\dental\referrals-somerset) For advice telephone 0300 1240426

|  |  |  |
| --- | --- | --- |
| Surname: | Male / Female | |
| First Name: | Home Tel No: |  |
| Date of Birth: | Mobile Tel No: |  |
| Address: | Pt GMP details: | |
| Postcode: |

**Referring dentist’s details:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name:  Address:  Postcode:  Tel No. | | | | | | | Refer to **EITHER** Primary Care DwSI MOS **OR** Maxillofacial Dept see guidelines. | | | | | | |
| **Primary Care DwSI MOS** Indicate DAC  Bridgwater 🞎 Frome 🞎 Taunton 🞎 Yeovil 🞎 | | | | | | |
| **Hospital Maxillofacial Dept** Please indicate: | | | | | | |
| Hospital **and** Reason | | | | | | |
| **Yeovil** | | |  | **Non Dento-Alveolar** | |  |
| **MPH Taunton** | | |  | **Complexity** | |  |
| Part of NHS Band 2 course of treatment | | | | | | | **Bath RUH** | | |  | **Medical History** | |  |
| No |  | Yes |  | **Please enclose FP17RN** | | |  | | |  | **GA required** | |  |
|  | | | | | | | **Soft tissue lesion or biopsy required** | | | | | |  |
| **Reason for referral** | | | | | | | | | | | | | |
| **Clinical details** | | | | | | | | | | | | | |
| **URGENT?**  reason: | | | | | | | | | | | | | |
| **Radiographs enclosed:** None  OPT  Intra oral  If 1) no radiograph is enclosed or 2) enclosed radiograph is grade 3) please state reasons | | | | | | | | | | | | | |
| If requesting removal of third molars please indicate reason (see NICE Guidelines) | | | | | | | | | | | | | |
| Recurrent pericoronitis | | | | |  | Non restorable caries | |  | Contributing to Perio disease adj 7s | | |  | |
| Follicular cystic changes | | | | |  | Abscess/cellulitis | |  | Internal/External resorption | | |  | |

**Confidential Medical History - Please tick yes/no giving any relevant details**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No** | **Yes** | **Details** |
| Is the patient on any drugs or medicines?  Please list the drugs/medicines. |  |  |  |
| Is the patient allergic to Penicillin or any other drugs or medicine?  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 other chest complaint |  |  |
| Any other serious illness  If **YES** please specify |  |  |
| Does the patient smoke? |  |  |
| Is the patient pregnant? |  |  |

|  |
| --- |
| **I CONFIRM THAT I HAVE:** |
| Discussed and agreed with the patient the above treatment referral as detailed.  Explained that NHS charges may apply if this is not part of a Band 2 course of treatment.  Explained that the operating surgeon is the person with whom the final decision for treatment offered rests. (When appropriate, consultation with the GDP will be undertaken.)  Assessed that the treatment required is beyond my skills and/or experience. |

**I understand that:**

* **Incomplete forms will be returned for missing information to be supplied**
* **Inappropriate referrals to Hospital Maxillofacial Dept will be redirected to Primary Care MOS and may delay the patient’s start of treatment.**
* **Referrals made for routine extractions or procedures normally expected to be provided as core service within the NHS contract will be questioned by the PCT**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **GDC Number** | |  | | | |
| **Referring Dentist’s signature** | | **Referring Dentists Name** | | | **Date** |
|  | |  | | |  |
| **PCDS Admin only:** | |  | | |  |
| **Outcome of Triage 1**  Accepted 🞏 Rejected 🞏 Modified Pathway 🞏  OMFS to DwSI MOS 🞏 DwSI to OMFS 🞏 | | | | | |
| Final Location: | Referral form reviewed by: | | Date: | Assess 🞏 Assess & Treat 🞏 | |
| **Outcome of Triage 2 (if needed)**  Accepted 🞏 Rejected 🞏 Modified Pathway 🞏  OMFS to DwSI MOS 🞏 DwSI to OMFS 🞏 | | | | | |
| Final Location: | Referral form reviewed by: | | Date: | Assess 🞏 Assess & Treat 🞏 | |