|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | | | | | |
| **Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….………** | | | | | |
| **REFERRAL INFORMATION** | | | | | |
| **Name of Provider to Receive Referral ( ) URGENT**  **ROUTINE** | | | | | |
| **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: Click Link  <https://www.rcseng.ac.uk/-/media/files/rcs/fds/publications/periradicular_surgery_guidelines_2020.pdf> | | | | | |
| **TOOTH OF CONCERN** | | | | **REASON FOR REFERRAL**  Continued on separate sheet/ letter attached  Pain  Swelling  Sinus  Incidental radiographic finding  Please 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 de-cementation? YES  NO  Is this restoration sound? YES  NO | | | | **Is the tooth root filled?** YES  NO  **Is the root filling; to length and without voids?**  YES  NO  Oral 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 | |  |  |  | | --- | --- | --- | |  |  |  | |  |  |  | | NA | | | NA |
| **ANAESTHETIC** | | | | | |
| 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. 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 | | | | | |
| **MEDICAL HISTORY** | | | | | |
| ***Please attach up-to-date medical history form for all referrals*** *– referrals will be returned if not included* | | | | | |
| **Medical Conditions: Tick box 1if none. Complete if other.**  **1. No relevant medical history confirmed**    **Current Medication:**  **Bisphosphonates/Denosumab state no of years……..**      **Allergies:** | | **Tick ALL relevant boxes**  **☐ Warfarin\***  **☐ NOACs e.g. rivaroxaban**  **☐ Aspirin/Clopidogrel**  **☐ Bleeding disorders**  **☐ Bisphosphonates (oral)**  **☐ Bisphosphonates**  **☐ DMARDS (Drugs for rheumatoid conditions)**  **☐ Oral Steroids**  **☐ Uncontrolled Diabetes**  **☐ Valve replacement**  **☐ Immunosuppressant’s**  **☐ Chemotherapy** | | | |
| **FULL PATIENT DETAILS** | | | **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:** | | |
| **PATIENT GDP DETAILS *(if not the referrer)*** | | | **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** | | |
| **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 | | | | | |
| **PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** | | | | | |
| Has the patient understood and consented to the referral? YES  NO | | | | | |
| **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:**

**Details for where to refer in your region are found at page 21 onward in the Oral Surgery Referral Guidance Document access from the link** [**Here**](https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/%20%20%20%20%20)

**If in doubt, contact your local Oral Surgery Provider.**

**For Somerset Primary Care DwSI MOS Referrals Indicate requested provider stating “DAC Bridgwater • Frome • Taunton • or Yeovil”**

**If you feel the case is urgent but not suspected cancer, please contact your local provider in person to discuss.**

**For all suspected cancer cases please use the Relevant 2 Week Wait referral form which can be accessed from the link** [**Here**](https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/)