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| **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 findingPlease 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 |

|  |  |  |
| --- | --- | --- |
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 | 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/)