**This form is intended to be used only by a recognised Orthodontic Specialist to refer a patient to an Oral Surgery Provider**

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| Name of Provider You Are Referring To: Secondary Care Hospital or Primary Care Dental Access Centre |
| Name of Provider:- |
| REFERRAL INFORMATION |
| This form is only for Accelerated Referral to an Oral Surgery Provider accompanied the Orthodontic Rx Plan |
| 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** [x] **Surname:****First name:****Job Title:****GDC/GMC Number:****Practice Name:****Practice Address:****Town/City:****Postcode:****Telephone Number:****E-mail Address:** |
| REASON FOR REFERRAL/CLINICAL DETAILS. Please detail reason for referral and what you want us to do for your patient. (Please provide full details of the surgical treatment required as well as AGREED orthodontic plan)Supplemental correspondence attached with referral [ ]  State No of Pages ( )Best Contact number if urgent contact required.  Please refer to referral guidelines:https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/04/mcn-oral-surgery-referral-guidelines-for-gdps-Feb-2022V1-002.docx |
| TREATMENT REQUESTED [ ]  Extraction [ ]  Exposure / Bonding  [ ]  Other (please specify) |
| Is this patient happy to accept treatment under LOCAL ANAESTHETIC? If deemed to be appropriate. *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. Please provide all relevant radiographs from orthodontic planning to support surgical management. DPT [ ]  Intra Orals [ ]  CBCT [ ]  Secondary Care (Radiographs can be found on Trust PACS) [ ] Date Radiographs taken …………………… Return radiographs on completion of treatment? Yes [ ]  |
| MEDICAL HISTORY |
| *Please attach up-to-date medical history for all referrals – referrals will be returned if this is not included* |
| Medical Conditions: Tick box 1 if none. Complete if other1.No Relevant Medical History confirmed [ ]  Current Medication: \*Bisphosphonates/Denosumab state no of years…….. Allergies: No[ ]  Yes[ ]  Provide details  | **Tick ALL relevant boxes and provide full details**[ ]  Warfarin[ ]  DOACs e.g. rivaroxaban[ ]  Aspirin/Clopidogrel[ ]  Bleeding disorders[ ]  Bisphosphonates (oral)\*[ ]  Bisphosphonates (IV)\*[ ]  Denosumab\*[ ]  DMARDS (Drugs for rheumatoid conditions)[ ]  Oral Steroids[ ]  Uncontrolled Diabetes[ ]  Cardiac Valve replacement or history of SBE[ ]  Immunosuppressant’s[ ]  Chemotherapy |
| OTHER INFORMATION (E.g. Living arrangements, Legal guardian, Interpreter required) |
| PATIENT GP 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: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** [ ]  |
| 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 Southwest LDN. (Referral guidelines are available on the LDN 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:**

**Relevant information for Details of Oral Surgery Providers for the Southwest Region can be found on the Oral Surgery Referral Guidance Document 2022 Appendix 4 page 21.**

https://www.england.nhs.uk/south/info-professional/dental/dcis/south-west-ldn/