**Head and Neck Suspected Cancer referrals must be submitted via the Fast Track Office, either via Choose & Book (preferred method) or Email
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/)

|  |
| --- |
| Name of Provider You Are Referring To: Secondary Care Hospital or Primary Care Dental Access Centre |
| Name of Provider:- |
| REFERRAL INFORMATION  |
| URGENT [ ]  ROUTINE [ ]  |
| 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:** |
| REASON FOR REFERRAL/CLINICAL DETAILS. Please detail reason for referral and what you want us to do for your patient. Please refer to referral guidelines:[Here](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/10/mcn-oral-surgery-referral-guidelines-for-gdps-Oct-2022V1-001.docx) |
| TREATMENT REQUESTED (for Apical Surgery and Wisdom tooth removal please use specific forms)[ ]  Extraction [ ]  Exposure & Bonding  [ ]  Biopsy [ ]  Other (please specify) |
| 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. 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. Date Taken……………….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 this is not included* |
| Medical Conditions: Tick box 1 in none. Complete if other1.No Relevant Medical History confirmed [ ]  Current Medication: Bisphosponates/Denusumab state no of years…….. Allergies:  | **Tick ALL relevant boxes**[ ]  Warfarin\*[ ]  NOACs e.g. rivaroxaban[ ]  Aspirin/Clopidogrel[ ]  Bleeding disorders[ ]  Bisphosphonates (oral)[ ]  Bisphosphonates (IV)[ ]  Denosumab[ ]  DMARDS (Drugs for rheumatoid conditions)[ ]  Oral Steroids[ ]  Uncontrolled Diabetes[ ]  Valve replacement[ ]  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:**

**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)

**Link to the Southwest Oral Surgery Referral Guidance** [Here](https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2023/05/mcn-oral-surgery-referral-guidelines-for-gdps-March-2023V4.docx)

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

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

**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/)