**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 other  1.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/)