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| **Name of Provider You Are Referring To: Secondary Care Hospital or Primary Care Dental Access Centre** | |
| **Name of Provider:-** | |
| **SECTION 1 - REFERRAL INFORMATION** | |
| **URGENT**  **ROUTINE** | |
| **SECTION 4 – FULL PATIENT DETAILS** | **SECTION 5 - 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.  **For Guidance see link below**  <https://www.rcseng.ac.uk/-/media/files/rcs/fds/guidelines/3rd-molar-guidelines--april-2021-v4.pd> | |

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| **WISDOM TOOTH TO BE REMOVED** | **UR8** | **UL8** | **LR8** | **LL8** |
| Second or subsequent episodes of Pericoronitis |  |  |  |  |
| Unrestorable caries in tooth/ adjacent teeth |  |  |  |  |
| Untreatable pulpal or periapical pathology |  |  |  |  |
| Abscess |  |  |  |  |
| Root resorption in tooth/ adjacent teeth |  |  |  |  |
| Fracture of tooth |  |  |  |  |
| Cyst |  |  |  |  |
| Periodontal disease affecting tooth/ adjacent teeth |  |  |  |  |
| Tooth causing traumatic occlusion |  |  |  |  |
| Previous attempted extraction |  |  |  |  |
| Other - please specify |  |  |  |  |

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| **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.**  DPT  Intra Orals  None (reason required)  …………………………………………………………………………..  Date Taken………………….  Return radiographs on completion of treatment? Yes | | |
| **MEDICAL HISTORY (referrals will be returned if this is not included)** | | |
| ***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 if 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)  Denusumab  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 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 requested provider 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/)