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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/)