**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/)

For all other referrals - please return fully completed forms to:  Patient Access Team, Bristol Dental Hospital, Chapter House, Lower Maudlin Street, Bristol, BS1 2LY.  Call Centre Tel: 0117 342 4422

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| --- |
| **PATIENT DETAILS** |
| **Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….………** |
| **SECTION 1 - REFERRAL INFORMATION** |
| **URGENT ☐** **ROUTINE** **☐** *(please tick)* |
| **SECTION 2 - TRIAGE INFORMATION** |
| **BDH USE ONLY** | **ROUTINE** |  | **UPGRADE TO FAST TRACK** |  |  |
| **URGENT** |  | **WITHIN 1 WEEK** |  | **WITHIN 2 WEEKS** |  |
| **DATE TRIAGED** |  |
| **PRINT NAME** |  |
| **RADIOGRAPH / CLINICAL PICTURES** |
| Is a diagnostically acceptable **RADIOGRAPH** included with this referral?Are **clinical pictures** included with this referral? | YES ☐NO ☐YES ☐NO ☐ |
| **CLINICAL REASON FOR REFERRAL.**  Please detail reason for referral and what you want us to do for your patient.☐ Ulcers ☐ Infection ☐ Soft Tissue Swelling ☐ White Lesion ☐ Pigmented Lesion ☐ Bone Lesion☐ Salivary Gland ☐ Pain ☐ Other   **Please attach referral letter if required.** |
| **DESCRIPTION OF LESION/CLINICAL FINDINGS:** |
| **PROVISIONAL DIAGNOSIS**. Please detail. |
| **SECTION 3 - ADDITIONAL INFORMATION** |
| **MEDICAL HISTORY -** Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history as needed. YES ☐, please detail. NONE ☐**Smoker** YES ☐, please detail. NONE ☐**Alcohol** YES ☐, please detail. NONE ☐ |
| **MEDICATION -** Please state type and dosage details. YES ☐, please detail. NONE ☐ |
| **ALLERGIES -** Please state allergy and description of reaction, if known. YES ☐, please detail. NONE ☐ |
| **OTHER INFORMATION** (E.g. Living arrangements, Legal guardian) |
| **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:** |
| SECTION 6 - PATIENT GP DETAILS ***(if not the referrer)*** | SECTION 7 - 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 ☐** |
| **SECTION 8 - PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT** |
| Has the patient understood and consented to the referral? YES ☐ NO ☐ |
| **SECTION 9 – CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER** |
| I confirm that this patient referral meets the current referral guidelines as issued by the Bristol Dental Hospital. (Referral guidelines are available on the BDH website). I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Please tick to confirm. ☐ |
| Print Full Name:………………………………………………………………………………………………… Date:………………………….................Signature: ……………………………………………………………………………… |

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