**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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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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