Adult - Oral & Maxillofacial Surgery Referral Form

Devon, Cornwall and Isles of Scilly Local Area Team

Patient's Details: **Title:** **First Name:** **Surname:** **Sex**: **Date of Birth:** **NHS Number:** **Telephone Numbers:** Home: Mobile:	**Address:** **Postcode:**
Date of Referral: **Date of last appointment with Dentist:**	**Has the reason for referral been explained to patient:** ☐
Referring Practitioner: **Name:** **Address:** **Tel:** **Email:**	**Patient's GMP:** **GMP Name:** **Address:** **Tel:**
Does the patient have a disability? Yes: ☐ **No:** ☐ **If yes please specify:**	

1a. Reason for Referral

Relevant tooth notation

R	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	L
	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	
	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	
	8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8	

1b. Reason for Referral:- Please select one or more of the following reason(s) and supply additional information in the box

Conscious sedation/GA **(GA/Sed request form attached)**	☐	Non third molar extraction	☐	Third molar extraction	☐
Retained Roots	☐	Apicectomy	☐	TMJ	☐
Abnormal soft tissue or bony lesion	☐	Oral Medicine /Salivary gland disease	☐	Facial deformity	☐

2. Details of why referral is necessary:
(To access current referral guidelines please click on the link below)
NHS England — South West » Dental referral guidance and forms

And go to Oral Surgery Referral Guidelines for GDPs

3. Medical History: - Please attach up-to-date medical history form for all referrals – referrals will be returned if this is not included	
Medical Conditions: **Current Medication:** **Allergies:** **Smoking / alcohol:** ***If the patient is taking Warfarin what is their most recent INR?**	**Tick ALL relevant boxes** ☐ Warfarin* ☐ NOACs e.g. rivaroxaban ☐ Aspirin/Clopidogrel ☐ Bleeding disorders ☐ Bisphosphonates (IV) ☐ DMARDS ☐ Oral Steroids ☐ Uncontrolled Diabetes ☐ Valve replacement ☐ Immunosuppressant's ☐ Chemotherapy Patient Signature: Date:

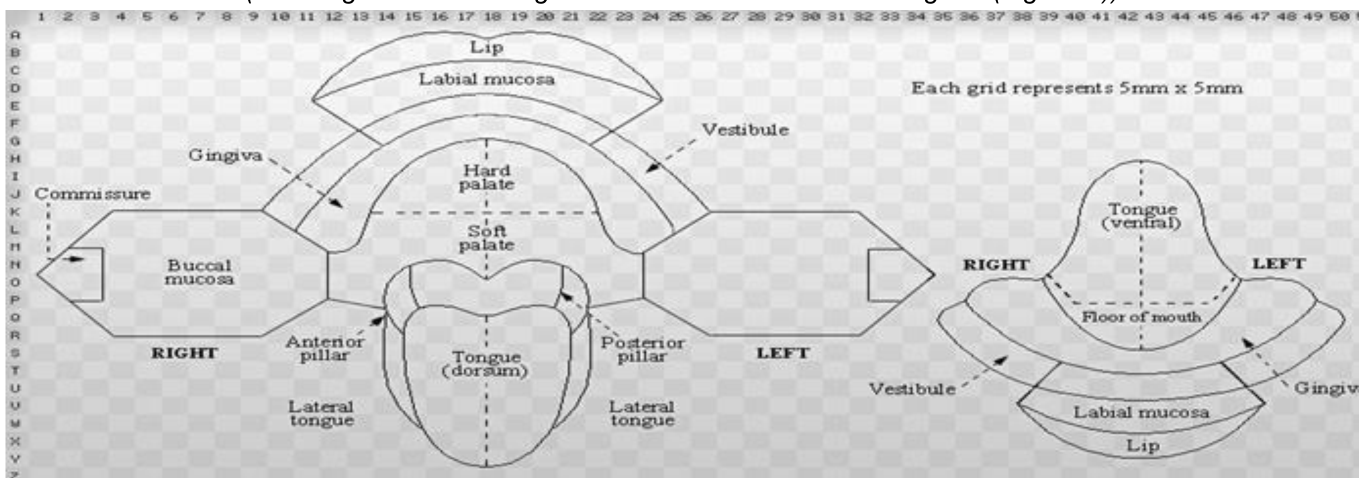
Patients Name:	**Patients Date of Birth:**

Suspected Malignancy: 2 Week Wait, Head and Neck Cancer referrals MUST be faxed/emailed to:

Royal Devon & Exeter Hospital	*Email: rde-tr.opafasttrackteam@nhs.net*	*(No fax)*
North Devon District Hospital	*Email: ndht.cancerbookings@nhs.net*	*Fax: **01271 311724***
Torbay Hospital	*Email: tsdft.headandneck2ww@nhs.net*	*Fax: **01803 654981***
Derriford Hospital	*Email: plh-tr.RK9Cancer2WW@nhs.net*	*Fax: **01752 430912***
Royal Cornwall	***Email:** rch-tr.suspectedcancer@nhs.net*	*(No fax)*

(For Torbay, Cornwall and Plymouth 2 Week Wait please use the appropriate form)

3. Oral Lesions:- *(Please give details and grid reference from the below diagram (e.g. D18))*



(Digital radiographs should be clearly printed)

Has a radiograph been attached; Yes: ☐ No: ☐ If not; please explain why below

Does your patient meet the criteria to be referred to a primary care based provider Yes: ☐ No : ☐

If your patient meets the criteria to be referred to secondary care do they have a preferred choice of provider (Please write):

Referring practitioner to sign below indicating completion of all relevant sections of referral form

Signature: **Date:**

Please send the completed referral proforma to:

Devon Patients	**Cornwall Patients**
Devon Referral Support Services (DRSS) Dental	Kernow Health Referral Management Service
Bridge House, Collett Way, Brunel Industrial Estate	1st Floor Cudmore House, Treliske Industrial Estate
Newton Abbot, TQ12 4PH	Truro, Cornwall TR1 3LP
Tel: 01626 883897	01872 226700
Email: d-ccg.drss-admin@nhs.net	Email: ciosicb.rmsdentalreferrals@nhs.net