Oral Medicine & Intra-Oral Soft Tissue Referral Form

Email to: gwh.omfs@nhs.net Photographs must be attached with all soft tissue referrals

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| **Patient details** |
| **Name** Enter patient’s full name | **Date of Birth** Click or tap to enter a date. |
| **Gender** Male [ ]  Female [ ]  | **NHS No** (Mandatory) Enter NHS number**GWH No** (if known) Enter GWH number |
| **Address**  Patient address**Postcode** Enter postcode |
| **Home telephone** Click to enter text. | **Mobile telephone** Click to enter text. |
| **Referral Information**: Routine [ ]   **URGENT** [ ]  **2WW** [ ]  (explain why in description of problem) |
| **Medical History:** (including medical conditions, medications, allergies/reactions, smoking and alcohol statusClick to enter text |



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| Reason for Referral:Description of problem, provisional diagnosis, treatment provided and treatment/service requestedPlease use anatomical terms for description where possible (see mouth map provided for terms)Photographs must be attached to all soft tissue referrals |
| Description of problem |



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| **Confirmation of consent:**I confirm I have discussed with the patient the nature of the referral [ ] I confirm that I have assessed the treatment required is beyond my skill/experience [ ]  I understand that incomplete or inappropriate referrals will be returned [ ]   |
| **Name of referring dentist** Click to enter text.**GDC number** Click to enter text. | **Date of referral** Click to enter a date. |
| **Address of referring dental practice** Click to enter text. |