**Routine Dento-Alveolar Referral Form**

**Email to:** [**gwh.omfs@nhs.net**](mailto:gwh.omfs@nhs.net)

|  |  |
| --- | --- |
| **Patient details** | |
| **Name** Enter patient’s full name | **Date of Birth**: Click to enter a date. |
| **Gender** Male ☐ Female ☐ | **NHS No** (Mandatory) NHS number  **GWH No** (if known) GWH number |
| **Address** Click to enter text.  **Postcode** Click to enter text. | |
| **Home telephone** Click to enter text. | **Mobile telephone** Click to enter text. |
| **Referral Information:** Routine ☐ **URGENT** ☐If so, why? Clinical reason for urgency | |
| **Diagnosis and treatment requested**:  Please state why this procedure cannot be performed in primary dental care, and outline any other treatment that is planned in primary care.  Click to enter text.   |  |  | | --- | --- | | Enter number | Enter number | | Enter number. | Enter number |   ***Please note: Referrals for orthodontic extractions/exposures will ONLY be accepted with an attached orthodontic treatment plan.*** | |
| **Medical History:** (include all medical conditions, medications, allergies/reactions, smoking and alcohol status, BMI)  Click to enter text. | |
| **Special requirements** (e.g interpreter, hoist, BSL)  Click to enter text. | |
| **Radiographs:**  Good quality radiographs MUST accompany this referral. If the radiographs are of insufficient quality, or are not enclosed without suitable explanation, we will return the referral to you until such time as we are in receipt of a suitable radiograph.  If you are unable to provide a radiograph, please explain why: Click to enter text. | |

|  |  |
| --- | --- |
| **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. | |