Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg University Health Board

Oral Surgery Referral Form

All NHS Referrals for patients requiring oral surgery must be made with this form
DO NOT SEND URGENT SUSPECTED CANCER REFERRALS ON THIS FORM
Referring practitioner to complete both sides
Incomplete forms will be returned

Prioritisation:

Routine ☐ Urgent ☐

GDP/CDO/Practice Stamp / Name & Address:	**LHB use only:** Date Rec'd: Patient identifier:
Please use BLOCK CAPITALS **Patients surname:** **First name:** **Date of birth:** **Address:** **Postcode:**	**Gender:** Male ☐ Female ☐ Height: Weight: BMI: **NHS Number:**

Home Telephone:

Mobile:

Work Telephone:

Reason for Referral (please tick all relevant boxes)**:**

Oral Medicine ☐ Dental Alveolar ☐ Third Molar extraction ☐

GA ☐ Local Anaesthesia ☐ Local Anaesthesia & Sedation ☐ *(anxious patients only)*

Enclosures (relevant especially for first line reasons for referral):

OPT ☐ Intra-orals ☐ Study models ☐ Other *(please specify)* ☐

OPG ☐ Yes ☐ No

If no, why? …

Date of last x-ray … … … … … … … … … … … …

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Presenting complaint / history of complaint

Medical History including allergies:	**tick if N/A** ☐

Medication:	**tick if N/A** ☐

Special care requirements (please detail if the patient has a disability or phobia):	**tick if N/A** ☐

The risks of general anaesthesia, local anaesthesia and conscious sedation have been explained to me.		Signature of patient and date
I have explained the risks of general anaesthesia, local anaesthesia and conscious sedation to the patient.		Signature of referring dentist and date
Prior to making this referral I have counselled the patient and they understand that treatment will be provided under local anaesthesia		Signature of referring dentist and date
The patient requires referral to the Community Dental Service as they have a disability and/or phobia and require oral surgery treatment under conscious sedation		Signature of referring dentist and date