Patient Referral Form - Minor Oral Surgery

Details of patient

Title ..... NHS number .....

First Name..... Surname .....

Male☐ Female☐ Date of birth ☐☐ ☐☐ ☐☐

Address .....

.....

Postcode .....

Telephone home .....

Telephone work .....

Mobile number .....

Interpreter needed? Yes☐ No☐

Please state language required.....

Copy of the referral given to the patient? Yes☐ No☐

Doctor's name and address (if dentist referring)

Address .....

.....

Postcode .....

Date received / /

Appointment date / /

Venue .....

Details of referring practitioner

Name and title.....

Practice name and address

.....

.....

Postcode .....

Telephone .....

Fax .....

Email .....

Details of the referral

If the referral is **urgent** – please contact the appropriate IMOS clinic to discuss:

Oasis Dental Care:	07500 780018
The Maltings Dental Practice:	01476 563181
The Forum Dental Studio:	01427 615117

Reason for the referral and treatment requested

Brief history of complaint

Diagnosis

Treatment options discussed

Treatment requested

(Please write in full the teeth requested for treatment)

PTO

Patient Referral Form - Minor Oral Surgery
Continued

Medical History

Current Medication

Please include details of any special requirements because of disability and mobility problems e.g. an induction loop, large print or wheelchair access)

Previous treatment associated with the tooth / teeth requiring treatment

Future Treatment arrangements

Radiographs

Radiographs attached Yes ☐ No ☐ Other (specify) .....

Digital .....

If none please state reason. .....

N.B. It is mandatory that you have undertaken a radiographic assessment of the tooth upon which to base your referral. If an attempt at extraction has been made / and or the tooth has fractured – please take a post operative radiograph and include. All analogue radiographs will be returned.

NICE Guidance in the Extraction of Wisdom teeth

Is this referral in line with NICE guidance on Extraction of Wisdom teeth: Yes ☐ No ☐

If not followed, give reason why not . .....

If an apicetomy requested, has the tooth been RCT'd / re-RCT'd Yes ☐ No ☐

If the form is not fully completed, it will be returned to you for missing information and will result in the delay of treatment to your patient

Signature of Referring Dentist ..... **Date** .....

IMOS clinics are based at the following locations: ***Please tick the clinic which the patient has chosen to be referred to.***

*Oasis Dental Care, 47 West Street, BOSTON, PE21 8QN ☐ Forum Dental Studio, Vanessa Drive, GAINSBOROUGH, DN21 2UQ ☐

The Maltings Dental Practice, Commercial Road, GRANTHAM, NG31 6DE ☐

*Oasis Dental Care, 33 The Strait, LINCOLN, LN2 1JD ☐ *Oasis Dental Care, 32 Algitha Road, SKEGNESS, PE25 2AJ ☐

***Please note that all referrals for Oasis Dental Care should be sent to: The Minor Oral Surgery Admin Office, Oasis Dental Care, 6 Carre Street, Sleaford, Lincolnshire, NG34 7TW for processing**