Wessex Area Minor Oral Surgery Referral Form

Patient's 1st Preferred Provider:	
Patient's 2nd Preferred Provider:	
Patient's 3rd Preferred Provider:	

REFERRAL FOR MINOR ORAL SURGERY
(Including Wisdom Teeth Removal In Line With NHS England - South (Wessex) Referral Criteria)

1. **Please complete all sections. Incomplete forms may be returned. Please include a radiograph. Please see notes 1.2, 1.3, 1.4 and 3.4 of the referral criteria.**
2. **This form should be typed or can be filled in digitally, and then printed. To integrate with your practice software, you may need to unprotect it.**
3. **NB. Please do not refer without reading the referral criteria.** The Minor Oral Surgery Referral Criteria which can be found online at the Solent NHS Trust Website: http://www.solent.nhs.uk/dental .
4. Please return to **Minor Oral Surgery Referral Centre, Solent NHS Trust Dental Single Point of Access, Level A, Royal South Hants Hospital, Brinton's Terrace, Southampton, SO14 0YG** Tel: 0300 300 2014
5. This form should **not** be used for **ORAL MEDICINE or TMJ referrals**. Write a normal letter directly to the appropriate Maxillofacial/Oral Surgery/Oral Medicine Department. Do not send these to the Minor Oral Surgery Referral Centre.
6. For the **2 WEEK CANCER FAST TRACK** referrals, use the forms specific to the appropriate hospital (See Referral Matrix for further information).

SECTION ONE – PATIENT DETAILS

Name	First name(s)	Surname
Gender		
Date of Birth	dd/mm/yyyy	
NHS No (if known)		
Address **Post Code**		
Landline: **Mobile:**		

SECTION TWO – DETAILS OF REFERRER

Referrer Name	
GDC Number	
Signature	
Date	
Practice Stamp or Address	
Practice ODS Code	
Practice Phone	
Practice NHS.net email	

☐ Please tick to confirm the referrer has read the appropriate NHS England - South (Wessex) Referral Criteria and is confident that the patient meets referral conditions.

☐ Please tick to confirm alternative treatment options have been discussed with the patient and that they have provided their consent for referral.

☐ Please tick to confirm agreement by practice contract holder for this referral to be made.

SECTION THREE – DETAILS OF GENERAL MEDICAL PRACTITIONER (G.P)

Please Note: *This information is* ***mandatory****. If this section is incomplete the referral will be returned to the referrer concerned.*

GP Name and Address	

For admin use only: Date Stamp	Triaged by:	Provider Code:	
		Treatment Code:	
		Level Code:	

Please repeat from page 1

Patient Name:	First name(s)	Surname	**DOB:**	

SECTION FOUR – MEDICAL HISTORY
(see notes **6.1** to **6.18** of Minor Oral Surgery Referral Criteria)
(Please attach MH form and drug list if available)

Medical conditions

Current medication

Allergies

Smoking / Alcohol

Disability

Tick all relevant
- ☐ Warfarin
- ☐ NOACs eg rivaroxaban
- ☐ Aspirin / Clopidogrel
- ☐ Bleeding disorders
- ☐ Bisphosphonates (IV)
- ☐ DMARDs
- ☐ Oral Steroids
- ☐ Uncontrolled Diabetes
- ☐ Valve replacement
- ☐ Immunosuppressants
- ☐ Chemotherapy

SECTION FIVE – REASON FOR REFERRAL

Please treat the following teeth (tickbox):

				E ☐	D ☐	C ☐	B ☐	A ☐	A ☐	B ☐	C ☐	D ☐	E ☐				
R	8 ☐	7 ☐	6 ☐	5 ☐	4 ☐	3 ☐	2 ☐	1 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	L
	☐ 8	☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	
				☐ E	☐ D	☐ C	☐ B	☐ A	☐ A	☐ B	☐ C	☐ D	☐ E				

Please provide below any additional information to support the referral including details of treatment already provided (please enclose all relevant radiographs):

What treatment are you requesting?

Indications for the treatment?

Why does it need to be done in intermediate / secondary care and not by you at your practice?

☐ Radiographs Enclosed *(please tick)*. If no radiographs enclosed please give reason: