Oral Surgery Referral Form

Dental Academy Bangor

Patient Information

Title and name:

Address:

Gender: D.O.B: DD/MM/YYYY

Email address:

Contact Number: (mobile preferred for SMS messaging):

NHS Number (if known):

Referrer Details

Referrer's Name:

Practice Name and Address:

Practice Postcode:

Practice phone number: GDC Number:

Patient's GP Name and Address:

If urgent care, please state why:

Interpreter required? Language? YES ☐ NO ☐ Please tick if a wheelchair user YES ☐ NO ☐

Please tick to confirm the patient consents to this referral and understands the reason for it: ☐

Patient Complaint

Reason For Referral

- ☐ Surgical removal of uncomplicated third molars involving bone removal
- ☐ Surgical removal of buried roots and fractured or residual root fragments
- ☐ Difficult extraction

Please Indicate Tooth Requiring Treatment

PLEASE BE AWARE THAT LOCAL ANAESTHETIC ONLY AVAILABLE. NO SEDATION AVAILABLE.

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BDA goodpractice

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Relevant Medical History

- [ ] Patient is healthy with no known medical conditions

- [ ] HIV / TB / CJD
- [ ] Heart problems
- [ ] Osteoporosis or bone / joint problems
- [ ] High blood pressure
- [ ] Skin conditions
- [ ] Asthma / COPD / Chest problems
- [ ] Mental health conditions
- [ ] CVD/Epilepsy / Neurological conditions / Parkinson's Disease
- [ ] Bleeding disorders/Coagulopathy /Sickle Cell disease
- [ ] Diabetes / Thyroid / Endocrine conditions
- [ ] Drug dependency
- [ ] Gastric disease
- [ ] Alcohol dependency
- [ ] Liver disease / Hepatitis
- [ ] Allergies
- [ ] Kidney disease
- [ ] Cancer

Has the patient had, or are they currently receiving:

- [ ] Chemotherapy
- [ ] Radiotherapy to the head and / or neck
- [ ] Bisphosphonates (oral / IV), if so please state type and duration in medications box below
- [ ] Anti-coagulant / anti-platelet medication, if so please state the type and duration in medications box below

Does the patient have a:

- [ ] Learning disability
- [ ] Hearing impairment
- [ ] Visual impairment
- [ ] Mobility impairment

Please give further details of medical conditions:

Please give details of ALL medications (if applicable):

I have read and understood the guidance notes for referrals of this type:

Signed: Date:

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