

## Minor Oral Surgery Referral Form



### Section 1- all sections to be completed by practice staff

Patient Name	NHS Number	
Address	GP Name GP Practice	
Postcode	Postcode	
Date of Birth	Email	
Contact Number	Home.....Work.....	Mobile.....

### Section 2- To be completed by patient- patient signature required as a minimum for this section

As a requirement under the Equality and Diversity Act the PCT is required to ensure services are equitable and fair for everyone. It is mandatory for the information below to be placed on this form but optional for patients to complete.

Gender                      Male                                            Female                     

Ethnic Origin:

Religion:

Sexual Orientation:

Special Care Requirements: e.g.  
wheelchair user, translation services

I understand that I have been referred for minor oral surgery assessment and treatment. Depending on the assessment made by the Oral Surgery specialist the outcome will be one of the following:- a) treatment reviewed/completed by my own dentist, b) treatment completed by the specialist in oral surgery, c) onward referral for treatment to be completed at Hertfordshire Salaried Dental Services, d) onward referral for treatment to be completed at an Acute Trust. I understand that as an NHS patient I am exempt from paying further charges. Private patients will be charged a Band 2 NHS dental fee. Information on Band 2 NHS dental fee is available on the NHS Choices website or please contact the PCT.

Parent/Patient Signature If 16 years or above	Date	
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### Section 3- all sections to be completed by referring dentist

Referring Dentist- please reference the referral protocol for guidance

Referring Dentist Name	Practice Address	
Practice Name		
Telephone:		
Email:	Postcode	

- This is an NHS patient -i.e. this treatment is part of a NHS Banded course evidenced by the attached FP17RN form
- This patient is currently treated privately but seeks NHS specialist advice/treatment

Signature	Date	
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- For suspected cancer, please use the Urgent cancer form, which needs to be faxed to the Trust
- Non cancerous soft tissue referrals should be sent directly to the Acute Trust
- This form is for the referral of Minor Oral Surgery that requires removal or teeth/root with bone removal or for assessment of TMJ problems. Please refer for all other specialist procedure to the correct service provider as listed in the directory.

**Forms incomplete/with no x-rays enclosed will be returned for missing information to be supplied**

Office use only-    MOS Specialist Practice    SCDS    Acute Trust    GDP

**Section 4- all sections to be completed by referring dentist**

Referral Details- please refer to referral criteria

- |  |   |
|--|---|
| <input type="checkbox"/> Failed extraction/Difficulty of extraction due to pathology   | <input type="checkbox"/> Removal or enucleation of simple dental cysts                            |
| <input type="checkbox"/> Buried roots/fractured root   | <input type="checkbox"/> Alveoplasty  |
| <input type="checkbox"/> Impacted/ectopic/supernumery teeth- includes those requiring removal as part of orthodontic treatment | <input type="checkbox"/> Apicectomy   |
| <input type="checkbox"/> Exposure of teeth   | <input type="checkbox"/> Removal of wisdom tooth - Please note below how this meets NICE guidance |
| <input type="checkbox"/> TMJ - Please provide further information  | .....   |

Tooth/Teeth requiring treatment	Relevant radiographs enclosed- N.B. bitewings no longer accepted		
<table border="1" style="width: 100%; height: 100%;"> <tr> <td style="width: 50%;"></td> <td style="width: 50%;"></td> </tr> </table>			<input type="checkbox"/> DPT/OPG <input type="checkbox"/> Other please state e.g paper digital xrays  <input type="checkbox"/> Periapical

Relevant medical history/If there is no relevant medical history -please state.  
 N.B there are very few medical conditions which require referral for surgical treatment please refer to referral protocol for guidance.

Treatment Required for Each tooth/ Brief History:

Please complete all preferences to prevent delays	
1. Preferred MOS specialist practice	Watton Place Clinic
2. Preferred Acute Trust (if not suitable for MOS specialist practice)	

**Referrals made for routine extractions or procedures normally expected to be provided under mandatory services within the NHS contract will be returned to the referrer and repeated inappropriate referrals may be reviewed by the PCT**

**Incomplete forms will be returned for missing information to be supplied**