**Temporomandibular Joint Dysfunction**

**Charles Clifford Dental Services Referral Form**

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| Patient name Click here to enter text.Title Click here to enter text. Female ☐ Male ☐  Date of Birth Click here to enter text.  Address\_Click here to enter text.  Post code Click here to enter text.  Home Telephone Click here to enter text.  Mobile Click here to enter text.  NHS number Click here to enter text. | Referrer name Click here to enter text.  **V. Code** (Dental Practices) Click here to enter text.  Address Click here to enter text.  Post Code \_Click here to enter text.  Tel No Click here to enter text.  E mail address Click here to enter text. |
| GP Name & Address: | |

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| History of the problem |
| **Medical history including details of current medication** |
| **Treatments already undertaken** |
| **Please state if this patient has been seen (or is seeing) any other secondary care provider for this condition** |
| **Please list any previous investigations undertaken – including scans** |
| **Please confirm patient is dentally fit and has had an oral cancer screen**  **(GPs should advice patients to seek a dental opinion)** |
| **Please confirm the patient has been provided with a dental splint** |
| **Urgent referral**  Please state reason for urgent referral and Fax to **01142717836** |
| **If referral from outside Sheffield please give details why referral is being made (please note we are not a specialist centre for TMD and can only offer services provided by OMFS locally)** |

**Supporting information**: Please see the NHS Sheffield Dental Referrals protocols handbook for information on referral criteria **Please use additional sheets if required**