**Oral Medicine**

**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.  |
| **Who is referring the patient**GP ☐ GDP ☐ Other Medical Specialty ☐ |

Date: Click here to enter a date.Age of patient Click here to enter text. Interpreter required ☐

 Language Click here to enter text.

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| **Reason for referral**  |
| **History of the problem including duration of symptoms; differential diagnosis; investigations already undertaken; treatment provided and current management** |
| **State if patient has been seen (or is seeing) any other secondary care provider for this condition** |
| **Medical history, medication and any allergies** |
| **Social history to include smoking and alcohol history** |
| **Any other relevant information** |
| **Urgent referral**Please state reason for urgent referral and Fax to **01142717836** |

**Supporting information**: Please see the NHS Sheffield Dental Referrals protocols handbook for information on referral criteria

 **Please use additional sheets/attachments if required**