**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**