**Oral Surgery**

**Charles Clifford Dental Services Referral Form**

|  |  |
| --- | --- |
| 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 | |

Date:Click here to enter a date. Interpreter required ☐

Language Click here to enter text.

|  |  |  |
| --- | --- | --- |
| **History of the problem** | | |
| **Your differential diagnosis** | | |
| **Duration of symptoms** Click here to enter text. | **Age of patient** Click here to enter a date. | |
| **Medical history including details of current medication** | | |
| **Please state if this patient has been seen (or is seeing) any other secondary care provider for this condition** | | |
| **Please list any previous investigations or treatment provided** | | |
| **Please confirm that the patient is dentally fit (GPs should advise patients to seek a dental opinion before referral if possible)** | |
| **Urgent referral** ☐  **Please state reason for urgent referral and Fax to 0114 2717836** | |

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

**Please use additional sheets if required**