**Oral & Maxillofacial Surgery**

**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 |

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

 Language Click here to enter text.

**Type of referral (please tick) Adult ☐ Paediatric ☐**

Head and Neck Pathology (not 2 ww) ☐ Facial Nerve Injury ☐

Trauma ☐ Other ☐

Deformity ☐

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| --- |
| **Please specify the exact treatment or opinion that is requested** **Please list treatment options discussed** **Please tick box to confirm that the referral meets the appropriate referral criteria** ☐  |
| **Medical History**  |
| **List of current medication** |
| **Urgent Referral ☐****Please state reason for urgent referral and Fax to 0114 2717836** |