**Head and Neck Suspected Cancer referrals must be submitted using the proforma at:**

**http://www.ruh.nhs.uk/For\_Clinicians/departments\_ruh/oncology\_services/documents/referral\_forms/Head\_&\_Neck\_Cancer\_2ww\_Proforma.pdf either via Choose & Book (preferred method) or via fax on 01225 825776**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| PATIENT DETAILS | | | | | |
| Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….……… | | | | | |
| SECTION 1 - REFERRAL INFORMATION | | | | | |
| URGENT  ROUTINE  *(please tick)* | | | | | |
| REASON FOR REFERRAL/CLINICAL DETAILS. Please detail reason for referral and what you want us to do for your patient. | | | | | |
| Tooth to be removed | UR8 | | UL8 | LR8 | LL8 |
| Second or subsequent episodes of Pericoronitis |  | |  |  |  |
| Unrestorable caries in tooth/ adjacent teeth |  | |  |  |  |
| Untreatable pulpal or periapical pathology |  | |  |  |  |
| Abscess |  | |  |  |  |
| Root resorption in tooth/ adjacent teeth |  | |  |  |  |
| Fracture of tooth |  | |  |  |  |
| Cyst |  | |  |  |  |
| Periodontal disease affecting tooth/ adjacent teeth |  | |  |  |  |
| Tooth causing traumatic occlusion |  | |  |  |  |
| Previous attempted extraction |  | |  |  |  |
| Other - please specify |  | |  |  |  |
| RADIOGRAPHS | | | | | |
| RADIOGRAPHS are required for patient assessment. If tooth is fully erupted a diagnostically acceptable radiograph is required. If tooth is partially erupted, a radiograph which justifies referral will be accepted (e.g. caries demonstrated in lower 7.)  Tick this box to confirm diagnostically acceptable radiograph sent with referral.  DPT  Intra Orals  None (reason required)  …………………………………………………………………………..  Return radiographs on completion of treatment? Yes | | | | | |
| SECTION 2 - ADDITIONAL INFORMATION | | | | | |
| MEDICAL HISTORY - Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history as needed. YES , please detail. NONE | | | | | |
| MEDICATION - Please state type and dosage details. YES , please detail. NONE | | | | | |
| ALLERGIES - Please state allergy and description of reaction, if known. YES , please detail. NONE | | | | | |
| OTHER INFORMATION (E.g. Living arrangements, Legal guardian) | | | | | |
| SECTION 3 – FULL PATIENT DETAILS | | **SECTION 4 – PATIENT PARENT/GUARDIAN, SCHOOL NURSE OR CARER DETAILS** *(if applicable)* | | | |
| Mr  Mrs  Miss  Ms  Dr  Other  Male  Female  NHS Number:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Work Number:  Mobile Number:  E-mail Address: | | Mr  Mrs  Miss  Ms  Dr  Other  Relationship to patient:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Work Number:  Mobile Number:  E-mail Address: | | | |
| SECTION 5 - REFERRER DETAILS | | **SECTION 6 - PATIENT GP DETAILS** *(if not the referrer)* | | | |
| Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Job Title:  GDC/GMC Number:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | | Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | | | |
| SECTION 7 - COMMUNICATION & SPECIAL REQUIREMENTS | | | | | |
| Does the patient communicate in a language or mode other than English? YES , please detail. NO | | | | | |
| Is an interpreter required? YES , please detail. NO | | | | | |
| Does the patient have any special requirements? YES , please detail. NO | | | | | |
| SECTION 8 - PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT | | | | | |
| Has the patient understood and consented to the referral? YES  NO | | | | | |
| SECTION 9 – CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER | | | | | |
| I confirm that this patient referral meets the current referral guidelines as issued by the Bristol Dental Hospital. (Referral guidelines are available on the BDH website). I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Please tick to confirm. | | | | | |
| Print Full Name:………………………………………………………………………………………………… Date:………………………….................  Signature: ……………………………………………………………………………… | | | | | |

**Please return fully completed forms to: Department of Oral and Maxillofacial Surgery, RUH NHS Foundation Trust, Combe Park, Bath BA1 3NG**