**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)* |
| CLINICAL REASON FOR REFERRAL. Please detail reason for referral and what you want us to do for your patient.  |
| 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**