Minor Oral Surgery Referral Form

NHS Hertfordshire

Section 1- all sections to be completed by practice staff

Patient Name	NHS Number	
Address Postcode	GP Name GP Practice Postcode	
Date of Birth	Email	
Contact Number	Home.....Work.....Mobile.....	

Section 2- To be completed by patient- patient signature required as a minimum for this section

As a requirement under the Equality and Diversity Act the PCT is required to ensure services are equitable and fair for everyone. It is mandatory for the information below to be placed on this form but optional for patients to complete.

Gender Male ☐ Female ☐

Ethnic Origin:

Religion:

Sexual Orientation:

Special Care Requirements: e.g. wheelchair user, translation services

I understand that I have been referred for minor oral surgery assessment and treatment. Depending on the assessment made by the Oral Surgery specialist the outcome will be one of the following:- a)treatment reviewed/completed by my own dentist, b)treatment completed by the specialist in oral surgery, c) onward referral for treatment to be completed at Hertfordshire Salaried Dental Services, d) onward referral for treatment to be completed at an Actute Trust. I understand that as an NHS patient I am exempt from paying further charges. Private patients will be charged a Band 2 NHS dental fee. Information on Band 2 NHS dental fee is available on the NHS Choices website or please contact the PCT.

Parent/Patient Signature If 16 years or above	Date	

Section 3- all sections to be completed by referring dentist

Referring Dentist- please reference the referral protocol for guidance

Referring Dentist Name Practice Name Telephone: Email:	Practice Address Postcode	

☐ **This is an NHS patient -i.e. this treatment is part of a NHS Banded course evidenced by the attached FP17RN form**

☐ **This patient is curently treated privately but seeks NHS specialist advice/treatment**

Signature	Date	

•For suspected cancer, please use the Urgent cancer form, which needs to be faxed to the Trust

•Non cancerous soft tissue referrals should be sent directly to the Acute Trust

•This form is for the referral of Minor Oral Surgery that requires removal or teeth/root with bone removal or for assessment of TMJ problems. Please refer for all other specialist procedure to the correct service provider as listed in the directory.

Forms incomplete/with no x-rays enclosed will be returned for missing information to be supplied

Office use only- ☐ MOS Specialist Practice ☐ SCDS ☐ Acute Trust ☐ GDP

Section 4- all sections to be completed by referring dentist

Referral Details- please refer to referral criteria

- ☐ Failed extraction/Difficulty of extraction due to pathology
- ☐ Buried roots/fractured root
- ☐ Impacted/ectopic/supernumery teeth- includes those requireng removal as part of orthodontic treatment
- ☐ Exposure of teeth
- ☐ TMJ - Please provide further information
- ☐ Removal or enucleation of simple dental cysts
- ☐ Alveoplasty
- ☐ Apicectomy
- ☐ Removal of wisdom tooth - Please note below how this meets NICE guidance

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Tooth/Teeth requiring treatment	**Relevant radiographs enclosed- N.B. bitewings no longer accepted**
	☐ DPT/OPG ☐ Other please state e.g paper digital xrays ☐ Periapical

Relevant medical history/If there is no relevant medical history -please state.
N.B there are very few medical conditions which require referral for surgical treatment please refer to referral protocol for guidance.

Treatment Required for Each tooth/ Brief History:

Please complete all preferences to prevent delays

1. Preferred MOS specialist practice	
2. Preferred Acute Trust (if not suitable for MOS specialist practice)	

Referrals made for routine extractions or procedures normally expected to be provided under mandatory services within the NHS contract will be returned to the referrer and repeated inappropriate referrals may be reviewed by the PCT

Incomplete forms will be returned for missing information to be supplied