Head and Neck Suspected Cancer referrals must be submitted via the Fast Track Office, either via Choose & Book (preferred method) or Email
2-week-wait form can be downloaded at https://www.england.nhs.uk/south/info-professional/dental/dcis/forms/

Gloucestershire Oral Surgery Ltd Tier 2 Adult and Adolescent IMOS Service

REFERRAL

ROUTINE ☐ URGENT (please justify) ☐

FULL PATIENT DETAILS	REFERRER DETAILS
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐
Male ☐ Female ☐ NHS Number (if known):	Surname:
Surname:	Given name:
Given name:	Job Title:
Date of Birth:	GDC/GMC Number:
Age (must be aged 13 or over)	Practice Name:
Address:	Practice Address:
Town/City:	Town/City:
Postcode:	Postcode:
Telephone Number:	Telephone Number:
Mobile Number (if different):	E-mail Address:
E-mail Address:	

TREATMENT REQUESTED			
Surgical removal of teeth, buried roots and fractured or residual root fragments that cannot be managed by GDP	☐	Management of uncomplicated third molars including surgical extractions requiring bone removal	☐
Failed extraction that cannot be managed by GDP (Please include pre & post-operative radiographs)	☐	Management of uncomplicated impacted, ectopic teeth or supernumerary teeth, including surgical extractions requiring bone removal	☐
Minor soft tissue surgery e.g. frenectomy or to remove apparent non-suspicious lesions requiring appropriate histopathological assessment e.g. fibroepithelial polyps and mucoceles (Please include photographs)	☐	Other, please specify:	☐
Management of uncomplicated impacted teeth to include surgical exposure and bonding of orthodontic bracket or chain (Please include orthodontic treatment plan/justification)	☐		
☐ **I confirm that I have discussed the different treatment options and modalities with the patient and that LEVEL 2 surgical treatment is required.**			

PLEASE INDICATE ON THE CHART WHICH TOOTH OR TEETH REQUIRING TREATMENT OR INDICATE LOCATION OF SUPERNUMARY TOOTH OR TEETH WITH A "$"

UR8	UR7	UR6	UR5	UR4	UR3	UR2	UR1	UL1	UL2	UL3	UL4	UL5	UL6	UL7	UL8
LR8	LR7	LR6	LR5	LR4	LR3	LR2	LR1	LL1	LL2	LL3	LL4	LL5	LL6	LL7	LL8

URE	URD	URC	URB	URA	ULA	ULB	ULC	ULD	ULE
LRE	LRD	LRC	LRB	LRA	LLA	LLB	LLC	LLD	LLE

PLEASE CONFIRM IN WRITING WHICH TOOTH OR TEETH REQUIRE TREATMENT

LOCAL ANAESTHETIC / SEDATION

The patient should be suitable to accept treatment under LOCAL ANAESTHETIC +/- SEDATION.

General Anaesthetic requests cannot be accepted in Primary Care

Patients requiring LEVEL 3 treatment or treatment under General Anesthetic in Gloucestershire should be referred to Gloucester Royal Hospital via their referral portal.

LOCAL ANAESTHETIC ONLY ☐ **SEDATION ☐**

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 that justifies referral will be accepted (e.g. caries demonstrated in lower 7).

☐ Tick this box to confirm diagnostically acceptable radiograph sent with referral. Date Taken…….

DPT ☐ **Intra Orals ☐** **None (reason required) ☐……**

MEDICAL HISTORY

Please attach an up-to-date medical history form with all referrals

Referrals will be returned if this is not included

Relevant medical history

Relevant social history

(e.g. Living arrangements, Legal guardian, Interpreter required)

Allergies:

The following carry significant relevance to managing an oral surgery patient. Please tick any that apply

- ☐ Warfarin
- ☐ NOACs e.g. rivaroxaban
- ☐ Aspirin/Clopidogrel
- ☐ Bleeding disorders
- ☐ Bisphosphonates (oral)
- ☐ Bisphosphonates (IV)
- ☐ Bone modifying agents e.g. Denosumab
- ☐ DMARDS (Drugs for rheumatoid conditions)
- ☐ Oral Steroids
- ☐ Uncontrolled Diabetes
- ☐ Heart valve replacement
- ☐ Immunosuppressants
- ☐ Chemotherapy
- ☐ Radiotherapy to the head & neck region

ANY OTHER INFORMATION CONSIDERED RELEVANT TO REFERRAL

PATIENT GP DETAILS *(if not the referrer)*

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐

Surname:

Given name:

Practice Name:

Practice Address:

Town/City:

Postcode:

Telephone Number:

E-mail Address:

COMMUNICATION & SPECIAL REQUIREMENTS

If the patient requires communication in a language or mode other than English, please provide detail

If an interpreter is required, please provide detail

If the patient has any special requirements, please provide detail

PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT

Does the patient have capacity, and have they understood and consented to the referral? YES ☐ NO ☐

Please indicate if you treated this patient under The Urgent Care Band 4 charge YES ☐ NO ☐

Please indicate if you treated this patient under Band 2 or Band 3 Charge YES ☐ NO ☐

See the next section collection of patient charge

COLLECTION OF NHS PATIENT CHARGE

Referring an NHS Patient to a Tier 2 Provider

When referring for Tier 2 Oral Surgery under LA – (Advanced Mandatory Services Referral):

- **You must collect the patient charge (if applicable) as per the NHS treatment band INCLUDING the treatment you are referring for, unless treated under Urgent Care Band 4.**
- **You must complete the section 'Referred to Advanced Mandatory Services' when closing the patient's Course of Treatment FP17 return**

Please see here for details

I confirm that I have completed (closed) the course of treatment FP17 as above and charged the relevant Treatment Band fee (if applicable). Please tick to confirm. ☐

When referring for Tier 2 Oral Surgery under Sedation – (Advanced Services Referral):

- **You must collect the patient charge (if applicable) as per the NHS treatment band ONLY for the treatment they are completing**
- **The FP17 claim is completed in the usual way and no additional boxes need to be crossed.**

Please see here for details

Referring a Private Patient to a Tier II Provider

- **Patients referred to an NHS Tier 2 services from an exclusively private dental practice that has no provision to take an NHS fee will be charged the relevant NHS Treatment Band Fee by the Tier 2 Provider.**

This patient is a private patient and I have made the patient aware they will be charged the relevant treatment fee and/or sedation fee as applicable. Please tick to confirm. ☐

CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER

I confirm that this patient referral meets the current referral guidelines as issued by the Southwest LDN. (Referral guidelines are available on the LDN website). I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient management. Please note that it is now a mandatory requirement for referrers to provide their GDC or GMC Number on this form

Please tick to confirm. ☐

Print Full Name:
Date:
Signature:

Please return fully completed forms by nhs.net to:

dental.v81912@nhs.net

Please illustrate the email with the title "Gloucestershire IMOS referral" followed by the patient's initials and date of birth

For further information, please visit www.oralsurgeryltd.com