Referral Form

Maxillofacial Unit
Bradford Teaching Hospitals NHS Foundation Trust
St Lukes Hospital Bradford BD5 ONA

Urgent **Soon** **Routine** **One Stop**

Please complete both sides of this form and retain a copy for your records
Inappropriate referrals will be returned
Attached radiographs +/or photographs should be sealed in an envelope (marked with the patient details) and stapled to this form
All referrals will be clinically triaged and those that do not comply with the referral guidelines will be returned
Patients with suspicious white/red patches (suspected cancer referrals) should be referred directly to the fast track office using the fast track form and referral pathway.

To (Special interests in brackets but all colleagues will see referrals appropriate to OMFS)
Named clinician:
or
Shortest waiting list:
(please mark appropriate box)

Practitioner details Name of referring dentist: Practice name and address: Postcode: Tel. no: Fax. No.	**Patient's medical practitioner details** Name of GP: Practice name and address: Postcode: Tel. no: Fax. No.
Patient details First name: Surname: Address: Postcode: Date of birth: Mobile tel. no: Daytime tel. no: NHS number: Hospital number (if known):	**Attachments** (please tick) (Appropriate images are essential, if not attached please state reason) OPT Periapical Bitewing Occlusal Clinical photograph Other (please state) Reason for no radiograph where clinically indicated:

Pt consent to referral and associated treatment	Have you discussed the nature of the referral with the patient?	Yes	No
	Have you discussed the risks associated with the referral?	Yes	No
	Have you discussed risks of GA per GDC guidelines?	Yes	No
	Has the patient understood and consented to the referral?	Yes	No

Clinical reason for referral – (patient complaint, provisional diagnosis/treatment, description of problem/lesion, previous attendance to OMFS for the problem)

Current treatment - in relation to this referral

Previous medical history

Medications: **Allergy status**:

Relevant social history :

Ambulance required? (state type if yes) Yes No

Interpreter required? (state language if yes) Yes No

Signature of referring practitioner: **Date:**

Print name:

Please check that all sections are complete to prevent return of the referral and delay in patient's management.
For those sections not applicable to this referral please put N/A. If any sections are blank the referral will be returned.
If you need more space please add another sheet with patient name and full details and staple to this form.
Please state number of stapled attachments: