

<b>London Intermediate Minor Oral Surgery Referral Form</b>			
<b>PATIENT DETAILS</b>			
Patient's Title and Name: <b>Mr. I.N. PAIN</b>		Gender: <b>M</b>	Date of Birth: <b>22/5/89</b>
Patient's Address: <b>53 STEINBECK AVENUE, NONSUCH, SURREY</b>		Postcode <b>KT6 7EE</b>	
Patient's email address: <a href="mailto:Inpain@hotmail.co.uk">Inpain@hotmail.co.uk</a>		Contact Number: <b>07009 882000</b> (mobile preferred for SMS messaging):	NHS Number (if known): <b>12345467</b>
<b>REFERRER DETAILS</b>			
Referrer's Name: <b>Mr. Patel</b>	Practice Postcode: <b>KT6 7UU</b>	Interpreter required? Language? <b>YES / NO -</b>	
Practice Name and Address: <b>DENTAL PRACTICE</b> <b>30 NOWHERE AVENUE, NONSUCH, SURREY</b>		Practice phone number: <b>020 8694 0000</b> GDC Number: <b>987654321</b>	
Patient's GP Name and Address including postcode: <b>NOWHERE SURGERY, 99 NOWHERE AVENUE, NONSUCH, SURREY, KT6 7UV</b> Practice E-mail address: <b>gp-H123499@nhs.net</b> Telephone: <b>020 8999 0000</b>			
If urgent care, please state why: <b>Not urgent</b>	Please tick if a wheelchair user <input type="checkbox"/>	Please confirm the patient consents to this referral and understands the reason for it: <input checked="" type="checkbox"/>	
<b>REASON FOR REFERRAL INTO IMOS SERVICE</b>			
Please tick one box and complete the Justification for Referral section below.			
<input type="checkbox"/>	Surgical removal of uncomplicated third molars involving bone removal	Surgical removal of buried roots and fractured or residual root fragments	
<input checked="" type="checkbox"/>	Management and surgical removal of uncomplicated ectopic teeth (including supernumerary teeth)	Management and surgical exposure of teeth to include bonding of orthodontic bracket or chain.	
<input type="checkbox"/>	Failed extraction	Other, please specify:	
<input type="checkbox"/>	Minor soft tissue surgery to remove apparent non-suspicious lesions with appropriate histopathological assessment and diagnosis, e.g. fibroepithelial polyp and mucocele.		
<b>REASON FOR REFERRAL INTO SECONDARY CARE</b>			
Please tick one box and complete the Justification for Referral section below.			
<input type="checkbox"/>	Extraction of erupted tooth/teeth/roots in medically compromised patients who cannot be managed in IMOS primary care	Extraction of impacted tooth/teeth in medically compromised patients who cannot be managed in IMOS primary care	
<input type="checkbox"/>	Orthodontic extractions/Supernumerary/Expose+/-bond in medically compromised patients who cannot be managed in IMOS primary care	Major facial and jaw trauma including fractures and soft tissue injuries	
<input type="checkbox"/>	Soft tissue swellings of the mouth, jaws, neck, thyroid and salivary glands	Complex hard tissue swellings of the mouth, jaws, neck, thyroid and salivary glands	
<input type="checkbox"/>	Complex oral and mucosal ulceration; red and white patches of the mucosa	Salivary and gland disorders (lumps, chronic/obstructive salivary diseases and complex mucoceles (ranula))	
<input type="checkbox"/>	Primary dentofacial deformity/orthognathic surgery	Complex dental cysts and cysts of the jaw	
<input type="checkbox"/>	TMJ – less than 2cm inter-incisal space	Other, please specify:	
<input type="checkbox"/>	Failed extraction		
<b>Idiopathic facial pain should be referred to the local facial pain service.</b> <b>Implants, bone grafting and apical surgery should be referred to restorative dentistry.</b>			
<b>Justification for Referral</b>			
Further information, including why specialist care is required and all previous treatment for the condition. For third molars, explain how NICE guidelines are met. For TMJ, provide details of interincisal opening and date and review for splint.			
<b>CLINICALLY DIAGNOSTIC, RELEVANT RADIOGRAPHS MUST BE ATTACHED FOR ALL EXTRACTIONS</b>			

**PLEASE INDICATE TOOTH REQUIRING TREATMENT**

**PERMANENT DENTITION**

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

**PRIMARY DENTITION**

E	D	C	B	A	A	B	C	D	E
E	D	C	B	A	A	B	C	D	E

**RELEVANT MEDICAL HISTORY FORM**

**DO NOT LEAVE ANY SECTION BLANK, ✓ FOR YES X FOR NO**

<input checked="" type="checkbox"/>	Patient is healthy with no known medical conditions	<input type="checkbox"/>	HIV / TB / CJD
<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	Osteoporosis or bone / joint problems
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Skin conditions
<input type="checkbox"/>	Asthma / COPD / Chest problems	<input type="checkbox"/>	Mental health conditions
<input type="checkbox"/>	CVD/Epilepsy / Neurological conditions / Parkinson's Disease	<input type="checkbox"/>	Bleeding disorders / Coagulopathy / Sickle Cell disease
<input checked="" type="checkbox"/>	Diabetes / Thyroid / Endocrine conditions	<input type="checkbox"/>	Drug dependency
<input type="checkbox"/>	Gastric disease	<input type="checkbox"/>	Alcohol dependency
<input type="checkbox"/>	Liver disease / Hepatitis	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	Cancer

**Has the patient had, or are they currently receiving:**

<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	Radiotherapy to the head and / or neck
<input type="checkbox"/>	Bisphosphonates (oral / IV), if so please state type and duration in medications box below	<input type="checkbox"/>	Anti-coagulant / anti-platelet medication, if so please state the type and duration in medications box below

**Does the patient have a:**

<input type="checkbox"/>	Learning disability	<input checked="" type="checkbox"/>	Visual impairment
<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	Mobility impairment

Please give further details of medical conditions:

**On medication for Diabetes but did not bring medication with him.**

**Advice given to patient to bring his medication to his IMOS appointment**

Please give details of ALL medications (if applicable):

**Not available**

**Any suspected malignancy of the mouth/jaws must be referred via the two week wait patient referral pathway.**

I have read and understood the guidance notes for referrals of this type:

*In Pain*

**Signed: SIGNED BY MR I.N .PAIN**

**Date: 30/5/2018**