

SSS Oral & Maxillofacial Surgery Referral Form

Local Anaesthetic Service Only

To help with efficient processing of referrals please ensure that **all** sections are completed accurately. If any information is missing or incorrect the referral will be returned.

Title:		First Name:				Surname:			
Dob:		NHS No.				Gender:	Male	Female	
Address and Postcode									
Home telephone				Mobile number:					
Is the above address a temporary address? Yes ☐ No ☐ If yes, please give details at the bottom of the next page									
I confirm that the patient is ready, willing and able to attend their appointment ☐									

GP Surgery:	
--------------------	--

Unfortunately SSS cannot accept patients who are not registered with a GP

Reason for referral and expected outcome:

Please ensure that the reason meets secondary care requirements.

Please confirm and mark below the tooth/teeth/root being referred:

UR	8□	7□	6□	5□	4□	3□	2□	1□	1□	2□	3□	4□	5□	6□	7□	8□	UL
LR	8□	7□	6□	5□	4□	3□	2□	1□	1□	2□	3□	4□	5□	6□	7□	8□	LL

Please note that any patient who DNAs their appointment will be discharged back to their dental surgery.

All referrals must be accompanied by radiology images. Please include one of the following:

☐ OPG ☐ Occlusal ☐ Periapical ☐ Bitewing

Referrer name:		Telephone:	
Practice Name & address			

Signed:

Dated:

Confidential Medical History – Please tick Yes/No giving any relevant details

	No	Yes	Details
Does the patient require any additional help with their appointments?	☐	☐	
Does the patient need an interpreter? <i>If yes please state which language</i>			

Has the patient ever had a general anaesthetic? If YES, where, when and what for.	☐	☐	
Has the patient taken drugs or medicines during the past 12 months? If YES, please give drug name.	☐	☐	
Is the patient allergic to Penicillin or any other drugs or medicines? If YES, please give drug name.	☐	☐	

Has the patient suffered from any of the following? Please give details:

Heart conditions	☐	☐	
Diabetes	☐	☐	
Allergies e.g. hayfever	☐	☐	
Fits or convulsions	☐	☐	
Fainting or Blackouts	☐	☐	
Bleeding problems	☐	☐	
Jaundice	☐	☐	
Asthma, bronchitis or any other chest complaint	☐	☐	
Any other serious illness If YES, please specify.	☐	☐	
Does the patient smoke?	☐	☐	
Is the patient pregnant? <i>Please ensure patients are aware treatment may be delayed until after pregnancy.</i>	☐	☐	
Please state any other relevant past medical history:			

Any other additional comments or information helpful to Somerset Surgical Services: