

# ORAL SURGERY REFERRAL FORM Urgent

**Please complete all sections of these forms and retain a copy for your records. Incomplete referrals will be returned.**

# Routine



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| **PATIENT DETAILS From:**  Full name: …………………………………………………………….……………………..……… **Referring Dentist:**  Parent / Guardian: ………………………………………….……………………..…………… Name & Address Practice Clinic ……………………………………………………………………….… Date of birth: ……………………………………………………….………………………….…. …………………………………………………………………...…………………………………………………….. Mobile tel. no.: ……………………………………………….……………………….…………. Tel. no. .………………………………………………………………………………………………..………….. Daytime tel. no.: ………………………………………………….……………………………… Fax no. .……………………………………………………………………………………………….…………… Parent’s/Patients’ address: Email: …………………………………………………………………………………………………………..…..  ………………………………………………………………………………….………..…………….…. Signature: ………………………………………………………………………………………………………..  …………………………………………………………………………………….………………………. Date: ………………………………………………………………………………………………………….……  **PATIENT’S MEDICAL PRACTICTIONER**  GP: ……………………………………………………………………………………..…………..……. GP Practice: ………………………………………………………………………………..…………………… Tel. no.: …………………………………………………………………………………….……….…. Fax no: …………………………………………………………………………………………………………….. |
| **RELEVANT MEDICAL HISTORY** – please give details of any medical conditions and medication |
| **REASON FOR REFERRAL** |
| **DETAILS OF PREVIOUS DENTAL TREATMENT / ONGOING DENTAL TREATMENT** |
| **TREATMENT REQUESTED (Dental Notation)**  Extraction |
| **PRE-REFERRAL CHECKLIST** – please tick to confirm you have checked the following:  Patient is over the age of 3 YES  NO   Is patient pregnant and in pain? YES  NO  *If Yes, please state which trimester ………………….*  Have you discussed the nature of the referral with the patient? YES  NO   Have you discussed the risks associated with the procedure? YES  NO  Has the patient understood and consented to the referral? YES  NO  Radiographs attached? YES  NO   Orthodontic treatment plan letter attached? YES  NO  |

**Please use this page for any further information you wish to include with your referral**