Abbotswood, Yate, Bristol, South Glos BS37 4NG. 01454 312981

CRITERIA FOR REFERRAL FOR ORAL SURGERY

Indications for care within a Primary Care Location

Lower Third Molars (8s)

- Within NICE Guidelines (essential)
- Partially erupted (essential)
- Vertical impaction with <5mm bone removal
- Mesio-angular impaction with <5mm bone removal without decoronation
- Disto-angular impaction with <5mm bone removal
- Horizontal impaction, with decoronation
- No associated pathology
- No ID Canal involvement
- Other considerations – complex medical history, age of patient

Extractions

- Symptomatic complex tooth extractions
- No antral involvement
- No ID Canal involvement
- INR <2.5 – 3-4 extraction with suturing, packing and Tranexamic acid
- Other considerations – complex medical history, age of patient, sedation (within GDC guidelines)

Retained Roots

- Symptomatic complex root extractions
- No antral involvement
- No ID Canal involvement
- No Lower Second Premolars
- Other considerations – complex medical history, age

Apicectomy

- Only after appropriate restorative assessment

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NHS MINOR ORAL SURGERY PATIENT REFERRAL FORM

PATIENT DETAILS	
Title:	Name:
Date of Birth:	Gender: M / F
Address in full:	
POST CODE:	
Evening Tel.	Mobile Tel.

Reason for referral (Diagnosis):

Treatment requested:
Special requirements:

MEDICAL HISTORY

1. Has the patient ever had or does he/she suffer from any of the following?

- Heart disorders Yes / No
- Chest problems e.g. asthma/bronchitis Yes / No
- High Blood Pressure Yes / No
- Kidney or Liver disease Yes / No
- Diabetes / Endocrine disorders Yes / No
- Epilepsy/Fainting attacks Yes / No
- Bleeding disorders Yes / No
- Disabilities or Learning difficulties Yes / No
- Previous General Anaesthesia/Sedation Yes / No
- Is the patient pregnant/ breastfeeding? Yes / No

- Does/has the patient used recreational drugs/narcotics? Yes / No
- Any other serious illness/operation? Yes / No

If yes to any of the above please give details:

2. Allergies

3. Current Medication

Declaration by dentist:

I confirm that these details are accurate and contemporaneous. I have discussed all treatment options with the patient. I am enclosing with this referral relevant radiographs as requested. I understand that the patient may not be seen if the referral is incomplete.

Signature of GDP……Date……..

PRACTICE STAMP / NAME AND ADDRESS OF DENTIST

GDP Name:

Dental Practice:

Telephone: