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

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.

Name and address of registered GMP:

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
- Anticoagulants or bisphosphonates therapy? 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…….

NAME AND ADDRESS OF DENTIST

GDP Name:	GDC Number:
Dental Practice: Telephone:	