SEFREF MINOR ORAL SURGERY FORM

Age of Patient in years:	Patient's Title & Name:	Sex	Date of Birth (DD/MM/YY) / /
Patient's Address:			
Patient's Town or City:	Preferred Contact No:		Patient's Postcode

Referrer's Name:	Practice Postcode:	Date of Decision to refer / /	Interpreter required? Language? ☐ YES / ☐ NO
Practice Name and Address:			Practice Phone Number:
GDC Number:	Care Type (Routine or Urgent)		URN:
If Urgent Care please state why:			Please tick here to confirm that patient consents to the referral and understands the reasons for it: ☐

RADIOGRAPHS *MUST BE* ATTACHED FOR ALL EXTRACTIONS – PLEASE SUPPLY PA'S OF THIRD MOLARS IF NO ACCESS TO DPT

Patient's GP Name and Address including Postcode:

Patient's principal complaint:

Please indicate requested anaesthesia:

- ☐ Local anaesthesia only
- ☐ IV Sedation (please complete IOSN form)
- ☐ GA (please complete IOSN form)

****If other describe here or use to provide more information. Please add additional sheets as necessary (quoting URN)**

Main Reason for referral:

- ☐ ROUTINE EXTRACTION OF TEETH*
- ☐ REMOVAL OF SIMPLE IMPACTED TEETH
- ☐ SURGICAL ENDODONTICS ON SINGLE ROOTED ANTERIOR TEETH
- ☐ REMOVAL OF BURIED / FRACTURED ROOT FRAGMENTS
- ☐ DIFFICULT EXTRACTION
- ☐ COMPLEX IMPACTION
- ☐ OTHER**

*** ROUTINE EXTRACTIONS ONLY ACCEPTED WHEN DETAILED JUSTIFICATION IS PROVIDED FOR WHY THIS CANNOT BE DONE IN PRIMARY CARE**
****PLEASE NOTE THAT THIS FORM SHOULD NOT BE USED FOR SUSPECTED CANCER REFERRALS.**
FOR ORAL MEDICINE REFERRALS PLEASE USE THE MAXILLO FACIAL REFERRAL FORM
NOTE THAT INDICATING SEDATION / GA DOES NOT GUARANTEE PROVISION
GENERAL ANAESTHETICS ARE NOT AVAILABLE FOR HEALTHY ADULTS UNDERGOING ROUTINE PROCEDURES.

For extractions, please indicate below the teeth / roots to be removed

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

Please describe why specialist care is required? Please describe any previous treatment for the condition referred. For third molars please explain how NICE guidelines are met? NICE criteria must be completed or the referral form will be returned to you.

I have read and understood the guidance notes for referrals of this type (see details on reverse or at dental-referrals.org)

SIGNED:_____

PLEASE COMPLETE A MEDICAL HISTORY FORM – COPY URN TO THIS FORM – ENSURE ALL BOXES ABOVE ARE COMPLETED
ADDITIONAL INFORMATION / LETTERS ETC MAY ACCOMPANY THE REFERRAL BUT MUST REFERENCE THE URN