Oral & Maxillofacial Surgery
Charles Clifford Dental Services Referral Form

Patient name Click here to enter text.Title Click here to enter text. Female ☐ Male ☐ Date of Birth Click here to enter text. Address_Click here to enter text. Post code Click here to enter text. Home Telephone Click here to enter text. Mobile Click here to enter text. NHS number Click here to enter text.	Referrer name Click here to enter text. **V. Code** (Dental Practices) Click here to enter text. Address Click here to enter text. Post Code _Click here to enter text. Tel No Click here to enter text. E mail address Click here to enter text.
GP Name & Address	

Date: Click here to enter a date.

Interpreter required ☐

Language Click here to enter text.

Type of referral (please tick) **Adult** ☐ **Paediatric** ☐

Head and Neck Pathology (not 2 ww) ☐ Facial Nerve Injury ☐

Trauma ☐ Other ☐

Deformity ☐

Please specify the exact treatment or opinion that is requested

Please list treatment options discussed

Please tick box to confirm that the referral meets the appropriate referral criteria ☐

Medical History

List of current medication

Urgent Referral ☐

Please state reason for urgent referral and Fax to 0114 2717836