**Oral Medicine**

**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. |
| **Who is referring the patient**  GP  GDP  Other Medical Specialty | |

Date: Click here to enter a date.Age of patient Click here to enter text. Interpreter required

Language Click here to enter text.

|  |
| --- |
| **Reason for referral** |
| **History of the problem including duration of symptoms; differential diagnosis; investigations already undertaken; treatment provided and current management** |
| **State if patient has been seen (or is seeing) any other secondary care provider for this condition** |
| **Medical history, medication and any allergies** |
| **Social history to include smoking and alcohol history** |
| **Any other relevant information** |
| **Urgent referral**  Please state reason for urgent referral and Fax to **01142717836** |

**Supporting information**: Please see the NHS Sheffield Dental Referrals protocols handbook for information on referral criteria

**Please use additional sheets/attachments if required**