**Head and Neck Suspected Cancer referrals must be submitted via the Fast Track Office, either via Choose & Book (preferred method) or via fax on 0117 342 3266 http://www.uhbristol.nhs.uk/media/2281249/2ww\_bnssg\_head\_and\_neck\_referral\_2014\_-\_blank.pdf**

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT DETAILS | | | |
| Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….……… | | | |
| SECTION 1 - REFERRAL INFORMATION | | | |
| URGENT  ROUTINE  SUITABLE FOR STUDENT TREATMENT  *(please tick)*  *If recommended for student treatment, please ensure patient is aware of potential wait for treatment.* | | | |
| Is this referral for: A) Specialist Opinion Only?  OR B) Specialist Opinion and Treatment?  *(please tick)* | | | |
| RADIOGRAPH | | | |
| Is a diagnostically acceptable RADIOGRAPH included with this referral? | | YES NO Reason if not……..……………………………………………. | |
| CLINICAL REASON FOR REFERRAL. Please detail reason for referral and what you want us to do for your patient. | | | |
| PROVISIONAL DIAGNOSIS AND CURRENT TREATMENT PLAN IN ASSOCIATION WITH THIS REFERRAL. Please detail. | | | |
| RELEVANT PREVIOUS TREATMENT HISTORY. Please detail. | | | |
| SECTION 2 - ADDITIONAL INFORMATION | | | |
| MEDICAL HISTORY - Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history as needed. YES , please detail. NONE | | | |
| MEDICATION - Please state type and dosage details. YES , please detail. NONE | | | |
| ALLERGIES - Please state allergy and description of reaction, if known. YES , please detail. NONE | | | |
| OTHER INFORMATION (E.g. Living arrangements, Legal guardian) | | | |
| SECTION 3 – FULL PATIENT DETAILS | | **SECTION 4 – PATIENT PARENT/GUARDIAN, SCHOOL NURSE OR CARER DETAILS** *(if applicable)* |
| Mr  Mrs  Miss  Ms  Dr  Other  Male  Female  NHS Number:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Work Number:  Mobile Number:  E-mail Address: | | Mr  Mrs  Miss  Ms  Dr  Other  Relationship to patient:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Work Number:  Mobile Number:  E-mail Address: |
| SECTION 5 - REFERRER DETAILS | | **SECTION 6 - PATIENT GP DETAILS** *(if not the referrer)* |
| Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Job Title:  GDC/GMC Number:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | | Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: |
| SECTION 7 - COMMUNICATION & SPECIAL REQUIREMENTS | | |
| Does the patient communicate in a language or mode other than English? YES , please detail. NO | | |
| Is an interpreter required? YES , please detail. NO | | |
| Does the patient have any special requirements? YES , please detail. NO | | |
| SECTION 8 - PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT | | |
| Has the patient understood and consented to the referral? YES  NO | | |
| SECTION 9 – CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER | | |
| I confirm that this patient referral meets the current referral guidelines as issued by the Bristol Dental Hospital. (Referral guidelines are available on the BDH website). I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Please tick to confirm. | | |
| Print Full Name:………………………………………………………………………………………………… Date:………………………….................  Signature: ……………………………………………………………………………… | | |

**Please return fully completed forms to: Patient Access Team, Bristol Dental Hospital, Chapter House, Lower Maudlin Street, Bristol, BS1 2LY. Fax: 0117 342 4994. Call Centre Tel: 0117 342 4422.**

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| SECTION 10 - SPECIALITY SPECIFIC INFORMATION – PRIMARY CARE DENTAL SERVICE – SPECIAL CARE | | | | | | | | | |
|  | | | | | | | | | |
| PATIENT DETAILS – *Please enter patient identifier at top of each page.* | | | | | | | | | |
| Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….……… | | | | | | | | | |
| Surgery Visit  OR Domiciliary Visit  Please note: Only those who are house bound who are totally unable to leave their home are seen on a domiciliary basis. | | | | | | | | | |
| Special care needs: | | | | | | | | | |
| Social history: | | | | | | | | | |
| Exempt from charges: NO  YES  Benefit:…………………………… (Please attach copy of qualifying exemption certificate)  NHS dental charges will be applied unless proof of exemption is provided.  NB: If you are in receipt of the following you are not exempt: ●Aged over 65, ●Disability living allowance, ●Incapacity benefit including, income based. | | | | | | | | | |
| Sensory impairment: | | Hearing |  | Vision | |  | | Communication |  |
| Mobility: | | Can manage stairs |  | Can walk with frame | |  | | Can weight bear |  |
| Wheelchair |  | Bed-bound | |  | | Hoisting required |  |
|  | | | | | | | Details: | | |
|  | Are you currently under the care of a doctor or having hospital treatment for any condition? | | | | YES  NO | |  | | |
|  | Are you/could you be pregnant? Due date? | | | | YES  NO | |  | | |
|  | Do you have/have you ever had any of the following: | | | |  | |  | | |
| CVS | HEART DISEASE (e.g. angina, heart attack, heart murmurs, valve problems, heart surgery)? | | | | YES  NO | |  | | |
|  | Rheumatic fever, Endocarditis? | | | | YES  NO | |  | | |
|  | High blood pressure, Stroke? | | | | YES  NO | |  | | |
|  | Bleeding disorder, Taking anticoagulants, anaemia? | | | | YES  NO | |  | | |
| RS | ASTHMA, Bronchitis, TB other chest disease? | | | | YES  NO | |  | | |
|  | Smoker (past/present) – how many per day? | | | | YES  NO | |  | | |
| GI | HEPATITIS, jaundice, other liver disease? | | | | YES  NO | |  | | |
| GU | KIDNEY, urinary tract or sexually transmitted disease? | | | | YES  NO | |  | | |
| CNS | EPILEPSY, convulsions, neurological disease? | | | | YES  NO | |  | | |
|  | Learning difficulties? | | | | YES  NO | |  | | |
|  | Mental illness/ Psychiatric problems? | | | | YES  NO | |  | | |
|  | Alcohol or Drug addiction (past/present)? | | | | YES  NO | |  | | |
| END | DIABETES, thyroid, other hormone disorders? | | | | YES  NO | |  | | |
| LM | Bone or joint disease? | | | | YES  NO | |  | | |
|  | Skin disease e.g. Eczema, dermatitis? | | | | YES  NO | |  | | |
|  | ALLERGIES (E.g. penicillin, aspirin, paracetamol, latex, Elastoplast)? | | | | YES  NO | |  | | |
|  | Any other diseases or conditions? | | | | YES  NO | |  | | |
|  | Previous operations? | | | | YES  NO | |  | | |
|  | Previous serious illness or admissions to hospital? | | | | YES  NO | |  | | |
| Signed by patient/parent/carer: Date: | | | | | | | | | |