**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**

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| 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:  |