

QUEENSWAY TEESIDE ORAL SURGERY SERVICE (QTOSS) REFERRAL FORM

Dr Matthew Dorman BDS (Hons), FDSRCS, FFDRCSI, (Oral Surg), Dip SED

PATIENT DETAILS	
Name:	DOB:
Address:	Home Tel (H):
	Mobile Tel (M):
	Email (E):

REASON FOR REFERRAL (In accordance with policy referral protocols)	
<input type="checkbox"/> Extraction of special difficulty <input type="checkbox"/> Removal of wisdom teeth as indicated by NICE <input type="checkbox"/> Removal of buried roots/fractured or root fragments <input type="checkbox"/> Extraction of simple impacted, ectopic or supernumerary teeth <input type="checkbox"/> Exposure of teeth	<input type="checkbox"/> Minor soft tissue surgery (polyps, mucocoele, hyperplasia) <input type="checkbox"/> Apicectomy of single rooted tooth <input type="checkbox"/> Minor dental trauma (avulsions/ re-implantation of teeth) <input type="checkbox"/> Removal or enucleation of simple dental cysts

INDICATE TEETH FOR TREATMENT	
R	
	L

INDICATION FOR SEDATION (please tick)			
<input type="checkbox"/> No indication	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Invasive procedure	<input type="checkbox"/> Co-operation

RELEVANT RADIOGRAPHS ENCLOSED (please tick)		
<input type="checkbox"/> DPT	<input type="checkbox"/> Bitewings	<input type="checkbox"/> Periapical

RELEVANT MEDICAL HISTORY	GMP DETAILS (Must be completed)

REFERRING DENTIST DETAILS	
Name:	
Address:	Telephone:
	Email:
Signed:	Date: