**Oral and Maxillofacial Referral**

St. George's Hospital, Blackshaw Road, London SW17 0QT Tel: 020 8725 1233

Email maxfax.dentalenquiries@stgeorges.nhs.uk

**Please complete this form as comprehensively as possible. Referrals with insufficient information may be rejected. Please note we cannot accept referrals for patients who weigh in excess of 125kg for extraction of wisdom teeth as we do not have a bariatric chair within the department.**

|  |  |
| --- | --- |
| Name | Does the patient require an interpreter? □If yes what language?  |
| DoB |  |
| Address |  |
| Tel Number |  |
| Mobile number |  |

|  |  |
| --- | --- |
| Referring GP/GDP |  |
| Practice Address |  |
| Practice Tel |  |
| Date of referral |  |
| GP Name and address |  |

| **Medical History**  |  | Further Details  |
| --- | --- | --- |
| Operations / Hospital admissions  |  |  |
| Cardiac / Hypertension |  |  |
| Respiratory |  |  |
| Diabetes / Endocrine Gastrointestinal |  |  |
| Liver / Hepatitis |  |  |
| Renal |  |  |
| Bleeding Problems  |  |  |
| Neurological / Mental health |  |  |
| Allergy |  |  |
| Other  |  |  |

|  |  |
| --- | --- |
| Please list the patient’s current medications: |  |

|  |  |  |
| --- | --- | --- |
| Social History |  |  |
| Smoker  |  | Daily amount:  |
| Paan/Betel Nut |  |  |
| Alcohol  |  | Units: |

**Reason for referral**

**Radiographs:** please include any relevant radiographs taken in past 12 months

|  |  |
| --- | --- |
| GA |  |
| Third molar |  |
| Retained Roots |  |
| TMJ |  |
| Abnormal soft tissue or bony lesion |  |
| Oral Medicine |  |
| Salivary gland disease |  |
| Facial deformity  |  |
| Other |  |

**Further Details:**