**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.**

|  |  |
| --- | --- |
| 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:**