Minor Oral Surgery Referral Form

MOS HERTFORDSHIRE

NHS Hertfordshire

Section 1: All sections to be completed by practice staff	
Patient details	
Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Other ☐ _____	Date of Referral: / /
Forename:	Birth Date: / /
Surname:	Email Address:
Address:	NHS Number:
Postcode:	**GP details**
Tel (Home):	GP Name
Tel (Work):	GP Address:
Tel (Mobile)	
	Postcode:

Section 2: To be completed by the patient – patient signature as a minimum for this section	
As a requirement under the Equality and Diversity Act the PCT is required to ensure services are equitable and fair for everyone. It is mandatory for the information below to be included on this form but optional for patients to complete.	
Gender: Male ☐ Female ☐	Sexual orientation:
Ethnic origin:	Special care requirements: e.g. wheelchair user, translation services
Religion:	

I understand that I have been referred for minor oral surgery assessment and treatment. Depending on the assessment made by the Oral Surgery specialist the outcome will be one of the following: a). treatment reviewed/competed by my own dentist, b). treatment completed by the specialist in oral surgery, c). onward referral for treatment to be completed at Hertfordshire Salaried Dental Services, d). onward referral for treatment to be completed at an Acute Trust. I understand that as an NHS patient I am exempt from paying further charges. Private patients will be charged a Band 2 NHS dental fee. Information on Band 2 NHS dental fee is available on the NHS Choices website or please contact the PCT.

Parent / Patient Signature: If 16 years or above	Date: / /

Section 3: All sections to be completed by referring dentist	
Referring Dentist – please reference the referral protocol for guidance	
Referring Dentist Name:	Practice Address:
Practice Name:	
Telephone:	
Email:	Postcode:

☐ **This is an NHS patient – i.e. this treatment is part of a NHS Banded course evidenced by the attached FP17RN form**

☐ **This patient is currently treated privately but seeks NHS specialist advice / treatment**

Signature	Date: / /

For suspected cancer, please use the Urgent cancer form, which needs to be faxed to the Trust
Non cancerous soft tissue referrals should be sent directly to the Acute Trust
This form is for the referral of Minor Oral Surgery that requires removal of teeth/root with bone removal or for assessment of TMJ problems.
Please refer for all other specialist procedure to the correct service provider as listed in the directory.

Forms incomplete/with no x-rays enclosed will be returned for missing information to be supplied

MOS Specialist Practice use only - ☐ Acute Trust ☐ GDP ☐ GDP/Anxiety management ☐ GDP/SCDS

PLEASE COMPLETE SECTION OVERLEAF

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Section 4: All sections to be completed by referring dentist

Referral Details – please refer to referral criteria

- ☐ Failed extraction / Difficulty of extraction due to pathology
- ☐ Buried roots / fractured root
- ☐ Impacted / ectopic / supernumerary teeth – includes those requiring removal as part of orthodontic treatment
- ☐ Exposure of teeth
- ☐ TMJ – please provide further information
- ☐ Removal or enucleation of simple dental cysts
- ☐ Alveoplasty
- ☐ Apicectomy
- ☐ Removal of wisdom tooth – Please note below how this meets NICE guidance

Tooth / Teeth requiring treatment

Relevant radiographs enclosed – N.B bitewings no longer accepted

☐ DPT/OPG ☐ Periapical

☐ Other please state e.g. paper digital x-rays

Relevant medical history/if there is no relevant medical history – please state
N.B. there are very few medical conditions which require referral for surgical treatment please refer to referral protocol for guidance

Treatment required and brief history – please note each tooth and treatment required for each tooth together with a brief history

Completed forms to be returned to:

For Clinic 1 and 2 - please use the freepost envelopes

MOS Hertfordshire Ltd, 44 High Street, Ashwell, Baldock, SG7 5NR

For Clinic 3 - please use the freepost envelopes

MOS Hertfordshire Ltd, Victoria Dental Clinic, 103 Victoria Street St Albans, Herts AL1 3TJ

Please complete all preferences to prevent delays

Preferred MOS specialist practice (please tick preferred clinic)

- ☐ Clinic 1, Ashwell Dental Surgery (Nr Baldock)
- ☐ Clinic 2, Hoddesdon Dental Surgery (Hoddesdon)
- ☐ Clinic 3, Victoria Dental Clinic (St Albans)

Preferred Acute Trust (if not suitable for MOS specialist practice)

Referral made for routine extractions or procedures normally expected to be provided under mandatory services within the NHS contract will be returned to the referred and repeated inappropriate referrals may be reviewed by the PCT. Incomplete forms will be returned for missing information to be supplied

Please send your referral documentation in the relevant freepost envelope provided.

Contact our referral management team on **01462 742 353 / 01727 853 300** if you have any questions or need more freepost envelopes.

Please note the freepost service is the equivalent of second class mail delivery time.