Appendix 1

ORAL SURGERY REFERRAL PRO FORMA

PATIENT DETAILS

Mr☐ Mrs☐ Miss☐ Ms☐ Master☐ Dr☐

Surname ……

First name ……

Date of Birth ……

Address ……

……..

Post code ……

Contact No ……

CHI/HCN No……

Interpreter required? Y / N

First Language……

MEDICATION

URGENCY OF REFERRAL

Red Flag (i.e. suspected cancer only) ☐

Urgent ☐ Routine☐

CLINICAL DETAILS

Reason for referral

……

……

History of complaint……..…..

……

……

Pt symptoms……....

……

……

Investigations undertaken

……

……

Likely Diagnosis

……

……

Please attach radiographs/photographs where relevant

REFERRER DETAILS

GDP ☐ CDS ☐ Specialist ☐ GMP ☐

Name ……...

Practice ……..……

……..……

……..

Contact No ……..……..

Appendix 1

GMP DETAILS **As above ☐**

Name ……..

Practice …….

……..……..

……..……..

Contact No ……..……

MEDICAL HISTORY (INC ALLERGIES)

LESION DESCRIPTION (where applicable)

Site…….…

Size……

Shape……

Colour……

Margins……..…….

Findings upon lesion palpation……..

……..……

Findings upon palpation of lymphnodes…

……

RISK FACTORS

Tobacco usage (cigs/day)…….. **Alcohol usage (units/week)**……

PRINT NAME ……

SIGN NAME ……

DATE ……