

Reset Form

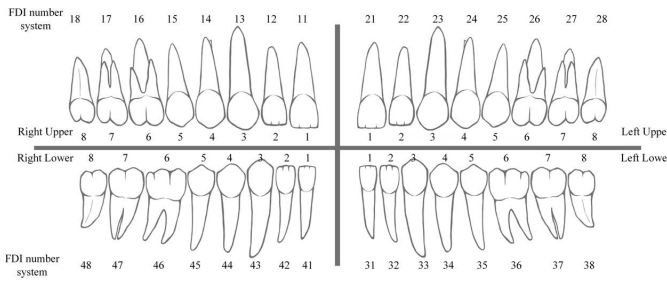
PRACTICE DETAILS

Referrer Name:	Date of referral:
Practice address:	Postcode: Tel: Email:

PATIENT DETAILS

Name:	Date of birth: (must be >16 y/o at time of referral)	Sex: Female Male
Contact address:	Tel (Home/work/mobile):	
Postcode:	NHS no/Hospital no:	
Medical history:		

Please state which service you would like:	Diagnosis & treatment planning	Treatment
--	--------------------------------	-----------

Charting of teeth present: 	BPE score: <table border="1" style="width: 100%; height: 40px;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%;"></td> <td style="width: 33%;"></td> </tr> <tr> <td></td> <td></td> <td></td> </tr> </table>						
<p>*ALL cases with a BPE score of 4 require a 6-point pocket chart and plaque score attached to the referral</p>							

Smoking status:	Never smoker	Previous Smoker	Current Smoker
If a previous smoker, when did the patient quit?			

<p>Please indicate (for our info) if the patient is in a high priority category below:</p> <p><u>Developmental Disorder</u> - e.g. hypodontia, cleft palate, amelogenesis or dentinogenesis imperfecta</p> <p><u>Trauma</u> -Teeth lost or of poor prognosis subsequent to trauma</p> <p><u>Head and neck cancer</u> -Previous surgery and/or radiotherapy</p> <p><u>Severe denture intolerance</u> - despite construction of technically acceptable dentures e.g. edentulous</p>

Please provide a brief history of the problem being referred and synopsis of recent intervention. Detail on the reason why this patient requires specialist restorative advice or treatment is required. Please attach all relevant radiographs and photos to the referral – periodontal, endodontic and trauma referrals WILL NOT be accepted without radiographs.

SIGNATURE

Date Signed:

SAVING & SUBMITTING THE FORM

Please attach and email it to leedsth-tr.restorativereferral@nhs.net from an NHS.net email account. Alternatively press the submit button below. Please also attach any radiographs or clinical photographs taken to your email.