Leeds Dental Institute Referral Protocols

1. Introduction

The purpose of the Dental Protocols is to provide a clinical framework to support clinicians when referring their patients for advice, treatment planning and/or specialist treatment

The following pages give details for each of the specialist services commissioned by NHS England within the Leeds Dental Institute.

The majority of patients accepted for specialist care will be those requiring a hospital based consultant led service.

The Dental Institute is also commissioned to provide education and training for undergraduate and postgraduate students as well as specialist training to consultant level. In order to support this aspect of work, patients with less complex needs will be considered for treatment by the training programmes.

For specialist and postgraduate training recruitment of suitable patients will be through consultant clinics.

For the majority of undergraduate clinics there is a separate recruitment website HERE where potential patients can register. They will then be seen for assessment and if appropriate for undergraduate dental care accepted for a single course of treatment.

Suspected Oral Cancer Referrals

For patients with suspected oral cancer please refer using the oral cancer referral form.

For referral of other urgent conditions by general dental practitioners please go to the main referral website (available at https://www.dental-referrals.org) and indicate the referral is urgent and the reason why.

Urgent Advice

For dentists/doctors seeking urgent advice please phone (0113) 244 0111 and a message will be passed to the relevant specialist department and consultant as soon as possible. Please state the nature of the urgent problem and leave your telephone or secure email contact details to allow for a prompt response.

2. Referral of patients

Accepting a referral

The clinician accepting a referral has a duty to fully understand the nature of the referral, and to offer appropriate management or advice. It is therefore important that all the relevant details are provided when referrals are made.

Whilst a patient is awaiting an appointment for consultation following referral, arrangements for emergency and routine treatment remain the responsibility of the referring clinician.

Inappropriate referrals will be returned to the referrer by the Leeds Dental Institute and the reasons for non-acceptance explained to both the referrer and the patient.

Treatment will only be carried out for the condition referred for. Any outstanding primary care condition will be returned to the GDP for completion. Patients should clearly understand this before referral.

3. Oral and Maxillofacial Surgery

Referrals from general dental practitioners should be sent electronically through the FDS system (https://www.dental-referrals.org) and from general medical practitioners through the e-Referral Service (formerly known as Choose & Book).

3.1 Management of Third Molars

Please see Yorkshire and Humber regional guidelines
https://www.dental-referrals.org/

3.2 Other impacted or buried teeth

Please see Yorkshire and Humber regional guidelines
https://www.dental-referrals.org/

3.3 Retained roots and failed extractions

Please see Yorkshire and Humber regional guidelines
https://www.dental-referrals.org/

3.4 Management of dental cysts and odontogenic tumours

Radiographic evidence of intra-bony pathology should be referred to the OMFS service for further management.

3.5 Salivary disease

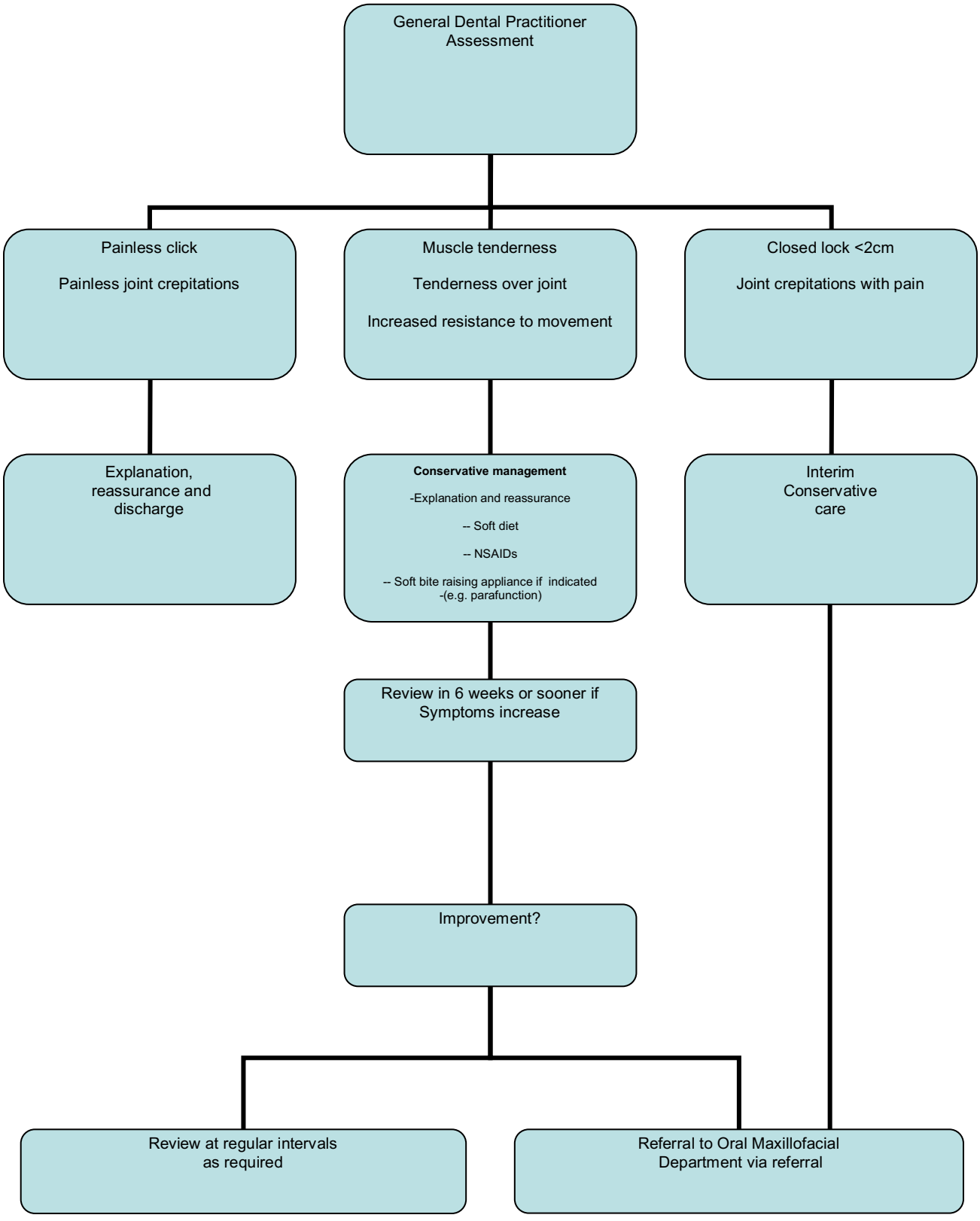
Patients with salivary disease, inflammatory or obstructive, should be referred to the OMFS service where surgical management is indicated.

3.6 Acute infections

Infectious conditions of the head and neck region which give rise to abnormal signs and symptoms should be referred to the OMFS service. Minor infections may be treated in accordance with '*Adult Antimicrobial Prescribing in Primary Dental Care for General Dental Practitioners'* produced by the Faculty of General Dental Practitioners (UK) Royal College of Surgeons.

3.7 Temporomandibular Joint Disorder (TMJ Disorder)

The following Flow Chart is to aid practitioners with the management and referral of TMJ Disorder patients



3.8 The management of abnormal bony and soft tissue lesions

The OMFS service will receive referrals for soft tissue lesions of the skin in the head and neck region and the intra-oral environment. Where an abnormal lesion is suspected to be malignant, patients must be referred for an urgent maxillofacial consultation. The Oral Cancer Referral Form (appendix 4) must be completed and faxed directly to the Leeds Dental Institute within 24 hours, Fax *No: 0113-3436264.*

All suspected cancer referrals adopt the 2 week wait cancer waiting times.

Warning signs of oral cancer are:

- Non-healing ulcer present for more than 2 weeks
- A lump or thickening in the cheek or elsewhere in the mouth
- A white or red patch on the gums, tonsils, or lining of the mouth
- Persistent soreness of the throat or mouth
- Difficulty chewing or swallowing
- Numbness of the tongue or other area of the mouth
- Swelling of the jaw that causes dentures to fit poorly or become uncomfortable
- Loosening of the teeth or pain around the teeth or jaw
- Voice changes
- A lump or mass in the neck
- Weight loss

Malignant lesions are often non painful at the time of presentation

3.9 Endodontic surgery

Please see Yorkshire and Humber regional guidelines https://www.dental-referrals.org/

4 Oral Medicine

Referrals from general dental practitioners should be sent electronically through the FDS system and from general medical practitioners through the eReferral Service (formerly known as Choose & Book)

4.1 Breadth of service

Oral Medicine is the specialty of dentistry concerned with the oral health care of patients with chronic, recurrent and medically related disorders of the oral and maxillofacial region, and with their diagnosis and non-surgical management.

The key difference from Oral Surgery and Oral & Maxillofacial Surgery is that in Oral Medicine the emphasis is on conditions that are primarily managed medically without the need for surgery.

The scope of Oral Medicine practice includes disorders of:

- Oral soft tissues (mucosa, tongue and lips)
- Salivary glands
- Neurological dysfunction including non-odontogenic (non-dental-related) pain

These disorders may reflect local oral problems or oral manifestations of systemic disease (e.g. gastrointestinal, rheumatological, dermatological, haematological, autoimmune, psychiatric or psychological disorders).

Oral Medicine acts as a focus for specialist interdisciplinary care of patients and there is close collaboration with other dental, medical and surgical specialties as required.

Many conditions that fall within the scope of Oral Medicine practice are chronic and may have a significant psychological, as well as physical impact on the patient's quality of life.

Referrals are accepted for:

Changes to the oral mucosa, tongue or lips* including:

- White lesions
- Red lesions
- Blistering conditions (vesicles or bullae)
- Ulcerated lesions - persistent (lasting over 2 weeks) or recurrent
- Pigmented lesions
- Lumps or swelling (focal or more generalised)
- Hypersensitivity reactions
- Stomatitis and cheilitis (including infections)
- Fibrosis

Changes to the saliva and salivary glands:

- Sensation of oral dryness or decreased saliva volumes
- Sensation of an overly wet mouth or increased saliva volumes
- Salivary gland swelling*

Changes to neurological function* including:

- Orofacial pain that is NOT due to dental disease such as caries or periodontal disease. e.g. burning mouth syndrome, trigeminal neuralgia & unexplained orofacial pain
- Altered sensation or abnormal motor function of oral structures

***Where cancer is suspected, then referral should be made via the urgent "Fast-Track" 2 week cancer service.**

Conditions that fall within the scope of Oral Medicine practice include:

- Angioedema
- Behçet's disease
- Chronic persistent facial pain
- Dysaesthesias including burning mouth syndrome
- Erythema multiforme
- Graft versus Host Disease (GvHD)
- Infections (viral, fungal or bacterial)
- Lichen planus
- Myofascial pain
- Orofacial granulomatosis and oral Crohn's Disease
- Pemphigoid
- Pemphigus
- Recurrent aphthous stomatitis and other forms of recurrent oral ulceration
- Sialorrhoea
- Sialosis
- Sjögren's syndrome
- Trigeminal neuralgia

5 Paediatric Dentistry

5.1 Referral Criteria

Any child up to 15 years of age (i.e. up to their 15th Birthday) that presents with oro-dental disease, where the management of their condition requires specialist/consultant management.

The acceptance criteria for referred patients are:

- Anxious or phobic children who cannot be successfully treated in general dental practice:
    - children where treatment has been tried and failed (in which case the treatment attempted and the problems encountered must be documented)
    - those for whom it is felt inappropriate to attempt definitive treatment in general practice e.g. under 3 years with rampant early childhood caries,
    - NB Where treatment has not been attempted, the referrer must explain why

- Children who have sustained complex dentoalveolar injuries.
- Medically compromised children whose delivery of care poses a risk.
- Children with inherited or acquired dental anomalies such as altered tooth structure, shape, size, form and number of teeth.
- Children requiring surgical exposure and/or surgical removal of unerupted incisor teeth, including where this is associated with supernumary teeth in the anterior maxilla. These children may also be referred to Orthodontics. Children requiring surgical exposure or removal of ectopic canine teeth should be referred to orthodontics or oral surgery.
- Children requiring investigation of disorders of eruption and shedding of teeth.
- Children with special care requirements who are not and could not be managed in general dental practice. Details of treatment attempted OR an explanation of why treatment has not been attempted should be included.

5.2 Children attending with dental emergencies

Same day emergency referrals can be made to LDI under the following circumstances:

- Acutely swollen face/systemically unwell
- Dental trauma requiring urgent specialist management
- Uncontrolled dental haemorrhage.

Where possible ALL emergency referral must be preceded by a telephone call (☎0113 3436229) to the department. A completed dental referral form including any appropriate radiographs (if available) should be sent with the patient, or faxed (0113 343 6282) so that it is available when the patient is seen. All emergency referrals will be triaged on arrival at LDI. Any that do not fulfil the above criteria will be returned to the referring practitioner without treatment being provided.

5.3 Children requiring treatment under General anaesthesia

Dental Practitioners referring patients specifically for GA are subject to the regulations laid down by the General Dental Council. In each case the referring practitioner should:

- Give a clear written justification for the suggested use of general anaesthesia.
- Provide details of any relevant medical history.
- Explain to the patients and parents or carers the risks associated with general anaesthesia, and gain consent for the referral
- Discuss alternative methods of providing the treatment.
- Provide details of the treatment deemed to be required.
- Retain a copy of their referral letter

It is important that the referral form contains information that confirms the above procedures have been completed, please use a separate sheet if needed. Failure to do so will result in the letter being returned to the referring practitioner. The final decision regarding treatment under GA or sedation will rest with the treating clinician.

5.4 Referral of children from outside Leeds

LDI will only accept referrals of children from out-with the Leeds area in the following circumstances:

1. From a local Consultant or Specialist in Paediatric Dentistry
2. Where a child requires multidisciplinary planning or tertiary care management which is not available in the child's local area.

- When in doubt, practitioners should refer to their local specialist provider (in most cases the Community Dental Services).
- Referrals for children not fulfilling one of the two criteria above and resident outside the Leeds area, and where suitable local specialist services exist (e.g. via the local Community Dental Service), will not be accepted.

6 Restorative Dentistry

The Restorative Dentistry Service at the LDI provides specialist treatment as well as a diagnostic and treatment planning service to referring practitioners. The intention of all consultants in restorative dentistry is to work in partnership with the referring dentist responsible for the routine dental care of the patient. This means that the patient may be referred back to the referring dentist for specific item of treatment or all of the recommended treatment with a detailed treatment plan where indicated.

The following general categories of patients are accepted for treatment within the relevant restorative sub-specialty:

- Oncology Patients: intraoral cancer resections, obturators and post radiotherapy management;
- Developmental defects: cleft lip and palate, severe hypodontia, joint orthognathic and/or orthodontic cases and amelogenesis, dentinogenesis imperfecta cases;
- Trauma: severe trauma (such as seen in patients following road traffic accidents) involving significant damage to the dentoalveolar complex.
- Severely medically compromised, e.g. patients with severe bleeding disorders, immunocompromised and post organ transplantation

6.1 Periodontics

Please ensure that the Periodontal Referral Form is completed in addition to the standard dental referral form.

Leeds Dental Institute provides:

- An assessment and advice service for periodontal patients
- Secondary care treatment by staff members as detailed in the criteria below
- Basic periodontal treatment by undergraduate dental students/ student hygiene and therapists*

Patients accepted for secondary care assessment **(not necessarily treatment)** include those with:

- **Severe chronic periodontal disease** defined as BPE scores of 4, where primary care treatment has been unsuccessful,
- **Aggressive disease**, judged by severity of periodontal destruction relative to age or rate of periodontal breakdown
- A need for **surgical management** (e.g. mucogingival procedures for recession defects, open flap debridement, regenerative procedures, crown lengthening)
- A **risk of severe periodontal disease due to a medical condition** (e.g. poorly controlled diabetes, drug induced gingival hyperplasia)
- A **risk of complications from periodontal treatment** (e.g. bleeding disorders, immunocompromised)
- A requirement for **complex restorative planning**

*A certain number of cases are required each year after which the waiting list may be closed Information about this is available HERE. There may be a significant delay in treatment commencing.

Please note that even if treatment in secondary care is anticipated, initial therapy should normally be carried out in the primary care setting, including:

- Oral health education: tooth brushing instruction/ interdental cleaning instruction
- Smoking cessation advice (if appropriate)
- Full mouth supra and subgingival debridement, carried out with local anaesthetic where required
- Periodontal charts recorded prior to and 2-3 months after completion of the above

All referrals should include the following:

- Periodontal Referral Form
- Basic Periodontal Examination (BPE) scores
- Periodontal charts including probing depths, mobility and plaque scores (pre and post treatment, taken within 12 months of referral)
- Confirmation that appropriate primary care, as detailed above, has been completed
- Radiographs **of diagnostic quality** if available

Referrals not meeting these criteria will be returned with a request for further information. Discharge procedures following periodontal treatment:

- Following treatment, patients are referred back to their practitioner with pre- and post-treatment charts and recommendations for a life-long supportive periodontal therapy programme. This emphasises the role of patients and primary care provider in disease management. Supportive care is essential for maintaining periodontal stability.
- There will be a percentage of patients who fail to adhere to the proposed treatment plan. These patients will be discharged with a plan for supportive care within the primary care sector, accepting that a gradual deterioration is likely.

6.2 Prosthodontics **(Fixed and removable complete and partial dentures)**

A limited number of patients may be accepted for specialist treatment, postgraduate training or undergraduate care, but only after the initial treatment by the referring practitioner has not been successful.

The following criteria should be met prior to referral:

- Patients should have good oral / denture hygiene
- Active caries, lost or fractured restorations should have been appropriately managed
- Significant periodontal disease should be appropriately managed

Otherwise, the patient will usually be discharged back to the referring dentist for provision of this treatment.

For the majority of removable prosthetics cases it is expected that the General Dental Practitioner has attempted treatment prior to referral.

Where dentures are obviously ill-fitting, the patient should have been provided with new dentures. They should only be referred if they continue to experience difficulties (unless reasons are given as to why this is inappropriate e.g. obturator construction). Referrals for removable prosthodontics must be made via the **Removable Prosthodontics Referral Form** as seen on the website.

If patients are offered treatment within the Leeds Dental Institute, their ongoing routine dental care and maintenance must still be provided within General Dental Practice. Patients should therefore continue to be seen for recalls and any routine treatment required whilst also undergoing treatment in the LDI. Patients will then be discharged back to their General Dental Practitioner following completion of treatment.

6.3 Endodontics

All referring clinicians must ensure that the Specialist Endodontic Referral Form 2017 (Appendix 3) is completed in addition to the standard dental referral form.

- The Leeds Dental Institute provides a diagnostic, treatment planning and advice service for patients with endodontic problems and specialist treatment when indicated

ENDODONTIC REFERRAL GUIDELINES
In addition to the standard referral form referrals must include:

- Fully completed endodontic referral additional information form
- A periapical radiograph of **diagnostic value**
- Confirmation that the tooth has a good periodontal and restorative status
- An important reason to retain a tooth

Referrals will be returned if:

- They are illegible
- The form is incomplete or does not meet the acceptance criteria detailed below

Criteria for acceptance for treatment:

- For advice only on endodontic problems and/or a pain diagnosis
- Root canals with anatomical complexities e.g. curvatures of >45^{o}
- Root canals that are NOT considered negotiable from radiographic or clinical evidence through their entire length. This is on the understanding that patients will be returned to you for completion of root canal treatment and final restoration where indicated.
- For endodontic complications of trauma e.g. tooth with open apices, root fractures etc.
- Peri-radicular surgery of failed RCT in the presence of **adequate conventional** obturation
- Pathological resorption

- Feasible removal of fractured instruments and intra-radicular posts in teeth of reasonable prognosis
- Root perforations
- Conventional re-treatment of failed root canal treatment

Patients will not be offered treatment if:

- They are not registered with a dentist
- They have poor oral hygiene, active caries and/or periodontal disease which is unmanaged
- The referral has been made on the patient's inability/unwillingness to pay NHS charges
- The prognosis for the tooth is considered poor
- They require sedation or GA for routine dental treatment
- The tooth is a molar unless it is of strategic value to the overall treatment plan

6.4 Tooth wear

A full diagnostic and advisory service is available. It is helpful if serial models or photographs to show the rapidity of the tooth wear where appropriate accompany referrals. In younger patients it is expected that a full dietary analysis will have been undertaken and appropriate advice given prior to referral. This might include the prescription of a fluoride mouth rinse where indicated

Patients will be directed back to their dentist for items of treatment that can reasonably be carried out within primary dental care.

6.5 Dental Implants

The criteria for implant placement on the NHS are strict, and the Leeds Dental Institute is only able to provide implant-based treatment to a limited selection of cases, which include:

- Developmental Disorder -Malformed, missing or ectopic teeth (e.g. hypodontia, cleft palate, amelogenesis or dentinogenesis imperfecta)
- Trauma -Teeth lost or of poor prognosis subsequent to trauma
- Head and neck cancer -Previous surgery and/or radiotherapy
- Severe denture intolerance - despite construction of technically acceptable dentures e.g. edentulous patients with severe ridge resorption, neuromuscular disorders etc

Referrals must be made via the Dental Implant Referral form. Please note that belonging to one of these categories does not guarantee that implant-based treatment can be offered at the Leeds Dental Institute. In most cases, alternative treatment options must have been attempted prior to consideration of implant placement (unless that is clearly not appropriate).

Patients **will not** be offered treatment if:

- They are not registered with a dentist
- They have poor oral hygiene, active caries and/or active periodontal disease
- They are a current smoker

The Leeds Dental Institute is **not** normally able to offer treatment in the following instances:

- Completion of implant treatment commenced outside of the NHS
- Management of failing implants or implant-retained prostheses provided outside of the NHS
- Maintenance of implants or restorations provided outside of the NHS

However, patients **may** be given special consideration if they are in one of the high priority categories listed above.

If patients are offered implant-based treatment, their on-going routine dental care and maintenance must still be provided within General Dental Practice. Patients should therefore continue to be seen for recalls and any routine treatment required whilst also undergoing treatment in the Leeds Dental Institute.

Following a review period after completion of implant-based treatment, patients will usually be discharged from the Dental Institute for maintenance in General Dental Practice.

7 Orthodontics

7.1 Referral criterion

All referring clinicians must ensure that the Specialist Orthodontic Referral Form is completed in addition to the standard dental referral form. Please include relevant current x-rays and ensure that they are marked correctly and securely attached. Study models must be packed securely in order to prevent damage in transit.

Patients should **only** be referred if they fulfil the criteria below.

- **The patient should be referred at the appropriate dental age**. Normally patients are ready for treatment when most of the permanent dentition has erupted. Generally, two premolars or a premolar and a canine should be erupted in all four quadrants.
  Exceptions to this rule are those children with severe malocclusions or where possible interceptive treatment, such as pushing an incisor over the bite or delayed tooth eruption or developing Class III, may require the child to be seen at a younger age (8-10 yrs). Patients with non-routine pathology such as root resorption or cysts should also be referred early.

- The patient's dental care must be adequate. Excellent oral hygiene i.e. no active gum disease or periodontal pockets, no bleeding on probing and no untreated caries. Careful dietary control is essential before orthodontic appliances can be placed in the mouth. If these fundamental criteria are not met then severe periodontal and tooth damage can occur during orthodontic treatment.

- **Patient motivation and "want" for treatment**. The probability of the patient having to wear either a removable or fixed brace to correct their problem should be fully discussed with the patient prior to their referral. There is little point referring a patient who is not prepared to commit to wearing an orthodontic appliance for up to 3 years.

7.2 Occlusal Indices

Orthodontics has a well developed series of national and international Occlusal Indices which can be used to assess treatment need for an individual patient. The index most often used to assess this is the Index of Orthodontic Treatment Need – IOTN.
The index has two components:

- Aesthetic Component (AC)
- Dental Health Component (DHC)

IOTN index.

NHS England only commissions services to treat child patients in **IOTN 3.6 = DHC 3 and AC 6** and above for orthodontic treatment. The LDI accepts very

few IOTN 3 grades and only a limited number of grade 4d are accepted for teaching or training purposes.

The detailed IOTN categories are as follows:

IOTN Grade 3 – Moderate treatment need

a. Increased overjet 3.5 mm but ≤6 mm with incompetent lips.
b. Reverse overjet greater than 1 mm but ≤3.5 mm
c. Anterior or posterior crossbites with 1 mm but ≤2 mm discrepancy between retruded contact position and intercuspal position.
d. Displacement of teeth 2 mm but to ≤4 mm.
e. Lateral or anterior open bite greater than 2 mm but ≤4 mm.
f. Increased and complete overbite without gingival or palatal trauma.

IOTN Grade 4 – Great treatment need

h. less extensive hypodontia requiring prerestorative orthodontics or orthodontic space closure to obviate the need for prosthesis
a. Increased overjet 6 mm but ≤9 mm
b. Reverse overjet 3.5 mm with no masticatory or speech difficulties
c. Anterior or posterior crossbites with 2 mm discrepancy between retruded contact position and intercuspal position
d. Severe displacements of teeth 4 mm
e. Extreme lateral or anterior open bites 4 mm
f. increased and complete overbite with gingival or palatal trauma
l. Posterior lingual crossbite with no functional Occlusal contact in one or both buccal segments
m. Reverse overjet greater than 1 mm but less than or equal to 3.5mm with recorded masticatory and speech difficulties
t. Partially erupted teeth, tipped and impacted against adjacent teeth
a. Supplemental teeth

IOTN Grade 5 – Very great treatment need

a. Increased overjet 9 mm
h. Extensive hypodontia with restorative implications (more than one tooth missing in any quadrant) requiring pre-restorative orthodontics
i. Impeded eruption of teeth (with the exception of third molars) due to crowding, displacement, the presence of supernumerary teeth, retained deciduous teeth and any pathological cause
m. Reverse overjet greater than 3.5 mm with reported masticatory and speech difficulties
p. Defects of cleft lip and palate
s. Submerged deciduous teeth

7.3 Details of Aesthetic component

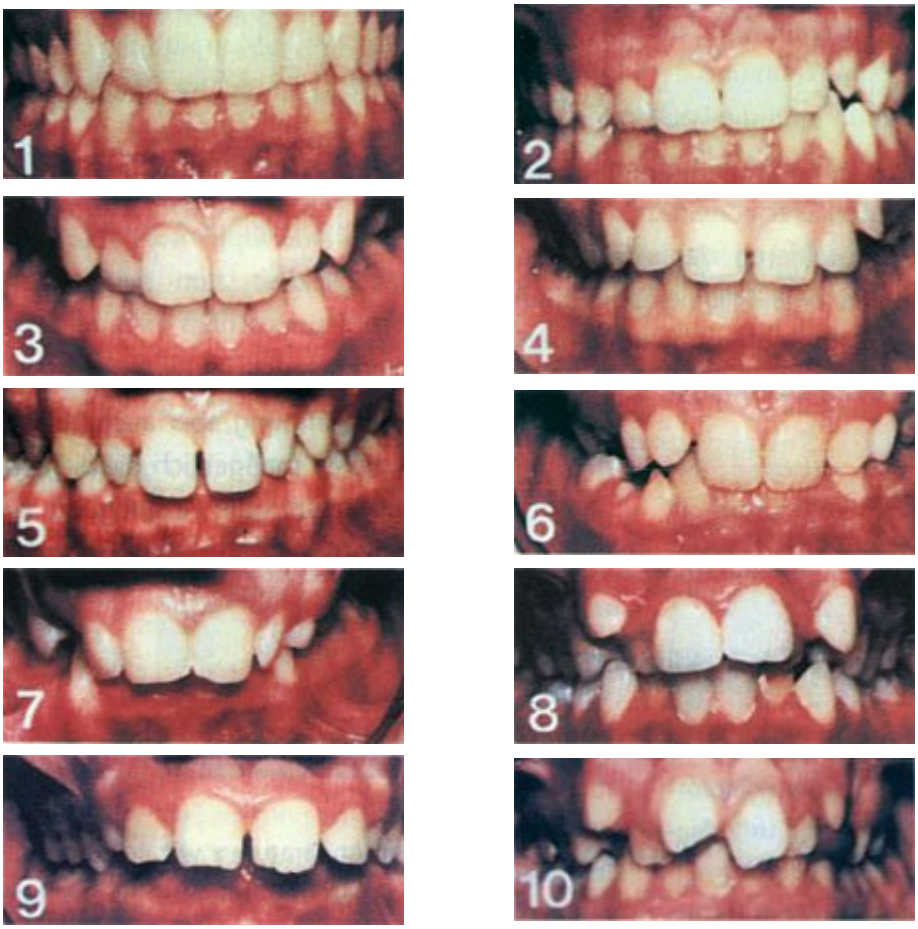
Grade 1 = most aesthetic arrangement of the dentition

Grade 10 = least aesthetic arrangement of the dentition

Grade 1-4 = little or no treatment required

Grade 5-7 = moderate or borderline treatment required

Grade 8-10 = treatment required



Please note:

Referrals will not be accepted unless there is a reasonable estimation of the IOTN DHC and AC grades on the referral proforma.

Always use the Dental Hospital orthodontic proforma for referring orthodontic patients.

8. Oral and Maxillofacial Radiology

General Dental and Specialist Practitioners may refer both private and NHS patients to the Dental Radiology Department for the following investigations:

- Panoramic radiography
- Cone Beam CT
- Second opinions on radiographs can also be sought

Under the Ionising Radiation Medical Exposure Regulations 2017 (IRMER 17) referrals will only be accepted if sufficient clinical information is provided to allow the radiographic investigation to be justified.

Panoramic radiography should be considered in the following clinical situations:

- Bony lesion or unerupted tooth not completely demonstrated on intra-oral radiographs
- Grossly neglected dentition for which multiple extractions are required*
- For the assessment of third molars prior to planned surgical intervention
- As part of an orthodontic assessment to determine the state of the dentition and the presence or absence of teeth
- Assessment of periapical status in the presence of multiple heavily restored and root-filled teeth
- Strong gag reflex preventing acquisition of indicated intraoral films. The indication of the intraorals should be provided.*
- Assessment of periodontal bone levels in the presence of one of the above indications, such as assessment of third molars, or in some cases an alternative to a full mouth periapical series (for example if this would provide a significant dose reduction)*

Panoramic radiography for visualising the TMJs can be considered in the following circumstances:

- Recent evidence of progressive pathology in the temporomandibular joints: recent trauma; change in occlusion; mandibular shift; sensory or motor alterations; change in range of movement

However, panoramic radiography of the TMJs will only be undertaken following assessment by a specialist.

*Examples of requests that will be rejected are:

- ‘Panoramic for caries and periodontal disease diagnosis.’
- ‘Panoramic as unable to obtain intraorals due to a strong gag reflex.’ Examples of requests that will be accepted are:

- ‘Panoramic requested due to multiple carious teeth requiring extraction and periodontal disease – generalised pocketing of 4-5mm (BPE scores of maximum Code 3 in any sextant with little or no recession.’

- ‘Periodontal disease – generalised pocketing of 6mm or more (BPE scores of Code 4). Panoramic requested as unable to obtain bitewings due to a strong gag reflex.’

Due to the greater resolution intra-orals attempts will be made to obtain these where possible.

CBCT could be considered in the following clinical scenarios where the clinical question cannot be answered with plain films:

- Implant planning,
- Jaw lesions*
- Assessment of unerupted/ectopic teeth
- Assessment of symptomatic wisdom teeth
- Dento-alveolar and facial trauma
- Surgical planning
- Foreign bodies/displaced roots involving the maxillary sinus

  *CBCT should not be used where soft tissue assessment is required or malignancy is suspected.

Referrals for radiographs for Cone Beam CT and second opinions should preferably be requested using the LDI Radiology Proforma and emailed to: leedsth-tr.RadiologyLDI@nhs.net.
Images will be returned on an encrypted CD and a radiographic report will be provided in all cases.

Please note if patients are being treated in General Dental or Specialist Practice as a private patient they will only be accepted for imaging on a private basis.

Second opinions

- The LDI Radiology Proforma should be completed for all requests for second opinions.
- The Proforma and digital radiographs (as JPEG email attachments) should be emailed to leedsth-tr.RadiologyLDI@nhs.net.
- The Proforma and conventional radiographs should be sent to Radiology Department, Leeds Dental Institute, Clarendon Way, Leeds LS2 9LU. All radiographs will be returned.
- In all cases, it is the Referrer’s responsibility to ensure that the correct images are matched with the correct patient.

Further information is available from Selection Criteria for Dental Radiography 3rd Edition 2013 - Editor K Horner, K A Eaton, Faculty of General Dental Practice (UK) for guidance (available from the FGDP) or by contacting the Radiology Department LDI (0113) 343 6213.