**Head and Neck Suspected Cancer referrals must be submitted using the proforma at:**

**http://www.ruh.nhs.uk/For\_Clinicians/departments\_ruh/oncology\_services/documents/referral\_forms/Head\_&\_Neck\_Cancer\_2ww\_Proforma.pdf either via Choose & Book (preferred method) or via fax on 01225 825776**

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT DETAILS | | | |
| Surname: …………………………………….……………… First name: ……………………..……………… Date of Birth: ………………….……… | | | |
| SECTION 1 - REFERRAL INFORMATION | | | |
| URGENT  ROUTINE  *(please tick)* | | | |
| REASON FOR REFERRAL/CLINICAL DETAILS. Please detail reason for referral and what you want us to do for your patient. | | | |
| TEMPOROMANDIBULAR DISORDER - QUESTIONNAIRE | | | |
| How long has the specific problem been present?  Is this a severe acute episode?  Has the patient received any explanation as to their diagnosis?  Has the patient received any specific advice/treatment for the problem?  Exercises?  Provision of an occlusal splint?  Has the patient been seen by other medical specialists? | | | ………………..  YES  NO  YES  NO  YES  NO  YES  NO  YES  NO  YES  NO |
| RADIOGRAPH | | | |
| Is a diagnostically acceptable RADIOGRAPH included with this referral? | YES NO Reason if not……..………………………………………… | | |
| SECTION 2 - ADDITIONAL INFORMATION | | | |
| MEDICAL HISTORY - Please include significant hospitalisation, operations, ongoing treatment and smoking/drinking history as needed. YES , please detail. NONE | | | |
| MEDICATION - Please state type and dosage details. YES , please detail. NONE | | | |
| ALLERGIES - Please state allergy and description of reaction, if known. YES , please detail. NONE | | | |
| OTHER INFORMATION (E.g. Living arrangements, Legal guardian) | | | |
| SECTION 3 – FULL PATIENT DETAILS | | **SECTION 4 – PATIENT PARENT/GUARDIAN, SCHOOL NURSE OR CARER DETAILS** *(if applicable)* | |
| Mr  Mrs  Miss  Ms  Dr  Other  Male  Female  NHS Number:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Work Number:  Mobile Number:  E-mail Address: | | Mr  Mrs  Miss  Ms  Dr  Other  Relationship to patient:  Surname:  First name:  Date of Birth:  Address:  Town/City:  Postcode:  Telephone Number:  Work Number:  Mobile Number:  E-mail Address: | |
| SECTION 5 - REFERRER DETAILS | | **SECTION 6 - PATIENT GP DETAILS** *(if not the referrer)* | |
| Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Job Title:  GDC/GMC Number:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | | Mr  Mrs  Miss  Ms  Dr  Other  Surname:  First name:  Practice Name:  Practice Address:  Town/City:  Postcode:  Telephone Number:  E-mail Address: | |
| SECTION 7 - COMMUNICATION & SPECIAL REQUIREMENTS | | | |
| Does the patient communicate in a language or mode other than English? YES , please detail. NO | | | |
| Is an interpreter required? YES , please detail. NO | | | |
| Does the patient have any special requirements? YES , please detail. NO | | | |
| SECTION 8 - PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT | | | |
| Has the patient understood and consented to the referral? YES  NO | | | |
| SECTION 9 – CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER | | | |
| I confirm that this patient referral meets the current referral guidelines as issued by the Bristol Dental Hospital. (Referral guidelines are available on the BDH website). I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment. Please tick to confirm. | | | |
| Print Full Name:………………………………………………………………………………………………… Date:………………………….................  Signature: ……………………………………………………………………………… | | | |

**Please return fully completed forms to: Department of Oral and Maxillofacial Surgery, RUH NHS Foundation Trust, Combe Park, Bath BA1 3NG**