LHDP REFERRAL CENTRE

Lansdowne House Dental Practice, 15 Chapel Street, Bromsgrove, Worcestershire B60 2BQ
Tel 01527 872098 **Email** bettersmiles@lhdpsmilecare.co.uk

www.lhdpsmilecare.co.uk

specialist oral surgery referral form

Practice Details

Referring Dentist: Date of Referral:

Referring Practice: Referring Dentist Email:

Practice Email: Practice Telephone Number:

Patient Details

Patient Title: Patient's Name: Patient's Email:

Patient's Address:

Telephone Numbers: Home: Work: Mobile:

Date of Birth: **Is this referral urgent?** ☐ Yes ☐ No

IV conscious sedation is available. Does your patient require sedation? ☐ Yes ☐ No

Teeth to be Extracted

Have other treatment options been discussed if appropriate? ☐ Yes ☐ No Details:

If third molar is to be extracted, has the patient been advised of the risks to the Inferior Dental Nerve? ☐ Yes ☐ No

Medical History

Allergies? ☐ Yes ☐ No Smoking? ☐ Yes ☐ No Alcohol? ☐ Yes ☐ No

Medication:

Warfarin ☐ Aspirin ☐ Novel Anticoagulants Rivaroxaban clopidogrel ☐

Steroids ☐ Immunosuppressants ☐ Bisphosphonates ☐

Cardiac valve replacement ☐ Chemotherapy ☐ Radiotherapy ☐ Other ☐

Any other information:

Dental History (Reason for extraction and patient symptoms)

Investigations (Already carried out)

☐ OPG ☐ PA's ☐ Other Radiographs ☐ CT Scan ☐ Are these enclosed?

Has the patient been informed of the cost of the consultation/treatment? ☐ Yes ☐ No

Has the patient been informed on the location of LHDP Referral Centre? ☐ Yes ☐ No

Would you like to be present at the consultation / surgery? ☐ Yes ☐ No

Referring Dentist Signature