

**Oral Medicine & Intra-Oral Soft Tissue Referral Form**

**Name:**

**Date of Birth:** DD **/** MM **/** YYYY

**MRN Number: NHS Number:**

(OR AFFIX HOSPITAL LABEL HERE)

[**www.gloshospitals.nhs.uk/glosmaxfax**](http://www.gloshospitals.nhs.uk/glosmaxfax)

Please advise your patients that treatment will most likely be performed at Cirencester Hospital. Please tick [ ] to confirm patient informed.

|  |  |
| --- | --- |
| **Patient details** | |
| Name | D.O.B |
| Gender Male  Female  | NHS No (Mandatory) |
| Address  Postcode | |
| Home telephone | Mobile telephone |
| Any medical conditions, allergies/reactions and medications | |

|  |  |
| --- | --- |
| Name of referring dentist (print name) | Date  **DD / MM / YYYY** |
| Address of referring dentist | |

TO BE FILED IN PATIENT’S HEALTH RECORD

**Tongue (ventral)**

**RIGHT**

**LEFT**

**Floor of mouth**

**Lip**



**Lip**

**Labial**

**Mucosa**

**Hard**

**Palate**

**Buccal**

**Soft**

**Mucosa**

**RIGHT Anterior Pillar**

**Tongue (dorsum)**

**Posterior Pillar**

**LEFT**

**Lateral Tongue**

**Lateral Tongue**

Provisional diagnosis and treatment requested. Please use mouth map

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