

**Routine Dento-Alveolar 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 |
| Diagnosis and treatment requested.  **Please state why this procedure cannot be performed in primary dental care.** | |
| All medical conditions, allergies/reactions and medications | |

**Radiographs**

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

Good quality radiographs MUST accompany this referral in accordance with the specification detailed on our website above. If the radiographs are of insufficient quality, or are not enclosed, we will regretfully return the referral to you until such time as we are in receipt of a suitable radiograph.

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

TO BE FILED IN PATIENT’S HEALTH RECORD

GHNHSFT/**Y1196**/10\_18 Review Date: 10\_21