

**Temporo-Mandibular Joint 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.***

The Faculty of Dental Surgery (RCS Eng) published detailed guidance in 2013 regarding the primary care management of Temporomandibular Discorders. It is clear form this guidance that secondary care intervention is only needed in a small number of cases.

[www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/](http://www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/) [www.gloshospitals.nhs.uk/glosmaxfax/tmj](http://www.gloshospitals.nhs.uk/glosmaxfax/tmj)

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| --- | --- |
| As a result we will now only accept TMJ referrals when there are the following (please tick) | |
| Intractable TMJ pain or persistent closed lock (less than 20mm trismus) that has not responded in 3 months to physio / jaw exercise, analgesia and a BRA / splint if indicated by the above guidance |  |
| Diagnostic doubt (see ‘Key Fact’ section of above document) |  |

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| --- | --- |
| **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) | |
| Signature | Date  **DD / MM / YYYY** |
| Address of referring dentist | |

TO BE FILED IN PATIENT’S HEALTH RECORD

GHNHSFT/**Y1197**/10\_18 Review Date: 10\_21