Curran Oral Surgery Referral Form

All sections must be completed. Please note incomplete referrals will be returned.

Patient name:	**Patients address and postcode:**	
Date of birth:		
Mobile number:	**Telephone number:**	
Payment source: NHS/ PRIVATE	**If NHS is patient exempt:** YES/ NO	**Health and care number:** Essential for NHS referrals
Interpreter required: YES/NO	**If YES specify language:**	
Medical history: Include a list of patients medical conditions	**Medications:** List of current medications	
Allergies:	**Smoking:**	**Alcohol:**
Mobility issues: wheelchair user or requires downstairs surgery YES/ NO		
Patients GP name, practice address and postcode:	**Patients GP telephone number:**	
Reason for referral: OPT ☐ Assessment ☐ Dental extraction(s) ☐ Orthodontic pilot ☐ Biopsy ☐		
History: Please include a summary of symptoms, diagnosis, treatment completed to date and treatment required		

Extractions required:
For extractions, please indicate the teeth/ roots to be removed below with an 'X':

Permanent dentition

☐8 ☐7 ☐6 ☐5 ☐4 ☐3 ☐2 ☐1	1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐
☐8 ☐7 ☐6 ☐5 ☐4 ☐3 ☐2 ☐1	1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐

Primary dentition

☐E ☐D ☐C ☐B ☐A	A☐ B☐ C☐ D☐ E☐
☐E ☐D ☐C ☐B ☐A	A☐ B☐ C☐ D☐ E☐

Treatment modality: Local anaesthetic ☐ IV sedation ☐ RA sedation ☐ *Please complete a separate pre-sedation assessment form and send with referral. Patients must be provided with pre-sedation instructions available on our website under 'patient information' prior to attending their appointment* *Patients having IV sedation should fast for 2 hours prior to their appointment and be accompanied by a responsible adult who can take them home and look after them for 24 hours following treatment*		
Radiograph(s) included: YES/ NO Radiographs must be included, please supply IOPA of third molars if cannot access OPT		**Date radiograph(s) taken:**
Reason radiograph(s) not included:		
Would you prefer this patient is seen by a particular clinician? YES/ NO	**If YES, which clinician:**	
Referring dentist name:	**Practice name, address and postcode:**	
Referring dentist email:		
Practice telephone number:	**Referring dentist signature:**	**Date of referral:**

Please send the referral form via:

Email: info@currandental.co.uk

Post: Curran Oral Surgery Clinic

434 Lisburn Road

Belfast

BT9 6GR

If you require any further information, please call us on: 028 90 667 979