Bristol Dental School Oral Surgery Referral Form

Please complete and post to: Patient Administration Team, Bristol Dental School, 1 Trinity Quay, Avon Street, Bristol, BS2 0PT
Email student-treatments@bristol.ac.uk or call if you have any questions or call 0117 374 6647.

ACCEPTANCE CRITERIA

General patient criteria as shown on our website:
bristol-dental-school-patient-acceptance-criteria.pdf

Since academic teaching is the primary aim, we are looking for people who meet the following criteria:

- Can commit to multiple appointments some of which may take up to 3 hours
- Can be flexible to attend on different days of the week, and able to attend the School
- Have dental needs that can be managed in a primary care setting
- Are reasonably healthy (See ASA reference table below):
  - ASA 1 – Clinically healthy
  - ASA 2 – Mild systemic disease without significant functional limitation
  - Some ASA 3 – Severe systemic disease with significant functional limitation – clinical
  - discretion advised
- Ambulatory and can transfer to a dental chair and are under the recommended weight limit for the dental chair.
- Non-ambulatory, but can accept treatment safely in a wheelchair in a dental cubicle or be transferred to a dental chair using accepted transfer aids.
- Are willing to have various aspects of their dental needs cared for by different students concurrently, under the supervision of a qualified dental professional

Oral Surgery

Pain and anxiety management:

- Patient must be self-assessed as not anxious using a Modified Dental Anxiety Scale (MDAS) questionnaire. Those assessed as very or extremely anxious are excluded.
- Patient will accept and be suitable for local anaesthesia alone for treatment (treatment under sedation or general anaesthetic not available).

Treatment complexity:

Level 1 (routine) procedures (Guide for Commissioning Oral Surgery and Oral Medicine, 2015) including:

- Routine extraction of erupted teeth (not impacted third molars or unerupted teeth)
- Extraction as appropriate of tooth roots (whether fractured during extraction or retained root fragments), including tooth sectioning.

TRIAGE INFORMATION (FOR BRISTOL DENTAL SCHOOL USE ONLY)

Is this referral for: *(please tick)*

A) Suitable for undergraduate student assessment ☐ **B) Not suitable** ☐

PATIENT CONSENT TO REFERRAL AND ASSOCIATED TREATMENT

Has the patient understood and consented to the referral and is happy (if accepted) for treatment to be delivered by undergraduate students in training, under the supervision of a qualified dental professional

YES ☐

REASON FOR REFERRAL

REASON FOR REFERRAL/CLINICAL DETAILS. Please detail reason for referral and what you want us to do for your patient.

TREATMENT REQUESTED

☐ Extraction

TREATMENT HISTORY. Please detail.

RADIOGRAPH

RADIOGRAPHS are required for patient assessment. If tooth is fully erupted or retained roots a diagnostically acceptable radiograph is required. Referral without acceptable radiographs will be rejected.

☐ Tick this box to confirm diagnostically acceptable radiograph sent with referral. Date Taken……

DPT ☐ Intra Orals ☐

Please provide as high quality printed images or as pdf if emailing to the above email address.

Please do not send wet processed films

MEDICAL HISTORY/SOCIAL DETAILS

Medical Conditions: Tick box 1 if none. Complete if other.

1. No relevant medical history confirmed ☐

Current Medication:

Tick ALL relevant boxes

- ☐ **Warfarin* (stable INR below 3.5)**
- ☐ **DOACs e.g. Rivaroxaban**
- ☐ **Aspirin/Clopidogrel/ other antiplatelet**
- ☐ **Bleeding disorders**
- ☐ **Bisphosphonates (oral/IV) (number of years**
- ☐ **Other bone modifying agents**
- ☐ **DMARDS (Drugs for rheumatoid conditions)**
- ☐ **Oral Steroids**
- ☐ **Uncontrolled Diabetes**
- ☐ **Cardiac Valve replacement**
- ☐ **Immunosuppressant's**
- ☐ **Chemotherapy**

MEDICATION LIST - Please state type and dosage details. Or attached prescription.

YES ☐ please detail. **NONE**☐

ALCOHOL COMSUMPTION **YES** ☐ Number of units a week. **NONE** ☐

SMOKER/VAPOUR/EX SMOKER **YES** ☐ Number of years and number per day. **NO** ☐

(delete as required)

Where appropriate, patients who smoke should be encouraged to cease the habit on the basis that treatment outcome, e.g. Perio, is often poor

ALLERGIES - Please state allergy and description of reaction, if known. **YES** ☐ please detail.

NONE☐

OTHER INFORMATION (E.g. Living arrangements, Legal guardian)

FULL PATIENT DETAILS	GDP (REFERRER) DETAILS
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐	Mr ☐ Mrs ☒ Miss ☐ Ms ☐ Dr ☐ Other ☐
Male ☐ Female ☐ NHS Number:	Surname:
Surname:	First name:
First name:	Job Title:
Date of Birth:	GDC Number:
Address:	Practice Name:
Town/City:	Practice Address:
Postcode:	Town/City:
Telephone Number:	Postcode:
Mobile Number:	Telephone Number:
E-mail Address:	E-mail Address:
PATIENT GMP DETAILS	**COMMUNICATION & SPECIAL REQUIREMENTS**
Practice Name:	Does the patient communicate in a language or
Practice Address:	mode other than English?
Town/City:	YES ☐ please detail. NO ☐
Postcode:	Is an interpreter required?
Telephone Number:	YES ☐ please detail. NO ☐
E-mail Address:	Does the patient have any special requirements?
	YES ☐ please detail. NO ☐

CONFIRMATION AND SIGNATURE OF REFERRING PRACTITIONER

Has the patient understood and consented to the referral and is happy (if accepted) for treatment to be delivered by oral health care professionals undergoing training?

YES ☐ NO ☐

Print Full Name:……

Date:……

Signature: ……