93 Robin Hood Way, London SW15 3QE T.02086 179 180 referrals@cherrytreedentistry.co.uk

Oral Surgery Referral Form (PLEASE COMPLETE ALL FIELDS)

Patient's name	Dr ☐ Mr ☐ Mrs☐ Miss☐ Ms ☐ Other……		
Date of birth		**Male / Female**	
Address (including postcode)			
Daytime telephone number		**Mobile telephone number**	
Patient Email			
Patients GP Practice Name			

Name of referring dentist (print name):	**GDC Number:**
Practice Name / Address:	**Postcode:**
Telephone number	

Date of referral	

Reason for Referral (please tick):

ORAL SURGERY IN PRIMARY CARE
☐ Complex surgical extraction of teeth (including severely impacted / partially erupted wisdom teeth)
☐ Patient requires sedation for minor oral surgery (Routine extraction)
☐ Apicectomies (Incisors/Premolars/ First Molar)
☐ Extraction of teeth following previous failed extraction (Retained roots / retrieval apicies)
☐ Treatments of patients with complex medical conditions, including those on warfarin / steroids / oral bisphosphonates.
☐ Post operative complications following extraction in GDS
☐ Frenectomy
☐ Removal of Fibrous polyps and mucocele type lesions (Non sinister features)

Tooth (teeth) requiring treatment	**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**

Relevant patient dental history **NB: A relevant medical history signed by the patient MUST be attached to this form**

Indication for Sedation	**Dental phobia / high anxiety**	**Difficult dental procedure**	**Strong gag reflex**	**Poor-co-operation**

If removal of third molars requested – please indicate reason within NICE guidelines

Surgical removal of impacted third molars should be limited to patients with evidence of pathology- Please indicate reason for referral for removal of wisdom teeth	**Please tick**
Caries in lower third molar not amenable to restorative measures	
Associated follicular cystic changes	
Lower third molar contributing to periodontal disease of second lower molar	
External or internal resorption of third molar	
Recurrent episodes of pericoronitis	
Restorable caries affecting distal aspect of second molars (evidenced with radiograph)	

Good quality radiograph(s) must be attached or e-mailed securely to referrals@cherrytreedentistry.co.uk **Please staple to the back of this form.** **If not attached please explain why**	**Number**	**Date Taken**

Dentist must sign to indicate that the reasons for referral have been explained to the patient and that they are being referred for private treatment.

Signature of referring GDP:……. Date: …….....

Referring Dentist to send this referral form and relevant enclosures to:

The Cherrytree Dental Care
93 Robin Hood Way, Kingston Vale, London SW15 3QE
Tel/Fax 02086 179 180
Email referrals@cherrytreedentistry.co.uk
www.cherrytreedentistry.co.uk