Oral Surgery (Jaw Necrosis Clinic)

Radiation and Medication related osteonecrosis of the jaw

**: : The Guy’s King’s and St Thomas’ Dental Institute of King’s College London : :**

***Guy’s & St Thomas’ Hospital NHS Trust***

*New Patient Referral Unit*

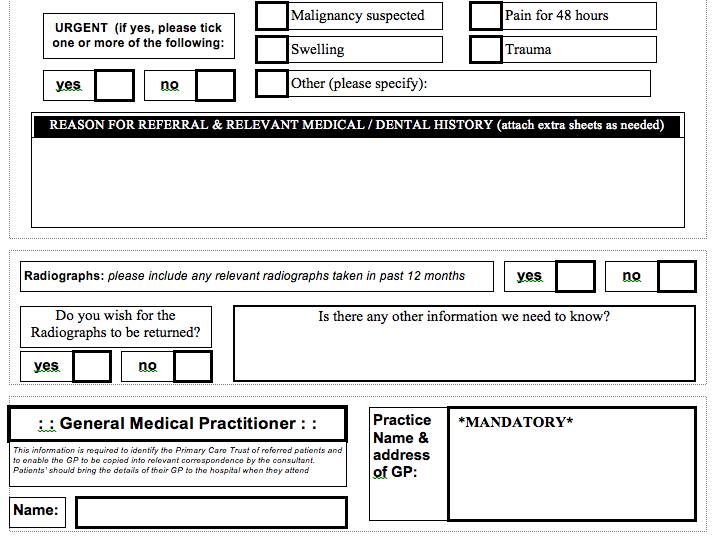
*Floor 25, Tower Wing*

# Guy’s Hospital

*Great Maze Pond. London SE1 9RT*

e-mail: [gst-tr.DentalReferrals@nhs.net](mailto:gst-tr.DentalReferrals@nhs.net)

Tel 020 7188 80062831



Name:

Hospital:

Address:

**: : Oncologist/Head & Neck Surgeon/Rheumatologist/ Other associated medical specialist ::**

**: : Oncologist/Head & Neck Surgeon/Rheumatologist/ Other associated medical specialist ::**

Name:

Hospital:

Address:

**Sex** *(please tick)* √

**: : A. Patient Personal Details : :**

**Date of Referral:**

**Patient’s Surname:**

**Female**

**Patient’s Forename:**

**Patient’s NHS Number: \*MANDATORY\***

**Patient’s Date of Birth:**

**Contact Address:**

**House Name**

**or Number and**

**Street Name**

**Town or City:**

**Postcode\*:**

**Home Phone:**

**e-mail Address:**

**Daytime Phone:**

**Mobile Phone:**

Does your patient need to communicate in a language or mode other than English? If yes, please specify:

g

**: : GDP Stamp / Address : :**

***Please ensure form is fully completed***

*King’s College* **: : The Guy’s King’s and St Thomas’ Dental Institute : :** *Guy’s & St Thomas’s Hospital NHS Trust of King’s College London Hospital NHS Trust*

**Signed:**

**(Dentist)**

*if manual copy*

**I confirm that this patient referral comes within the current referral guidelines issued by GKT Dental Institute**

***Please tick box to confirm* √**

**Print Name**

**(Dentist)**

**Male**