**Guy’s and St Thomas’ Dental Hospital (part of KCL Dental Institute)**

**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.DentalReferrals2@nhs.net **(each patient in a separate email please)**

Tel: 020 7188 8006

**A. Patient Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of referral: | Click here to enter a date. | Patient’s date of birth: | Click here to enter text. |
| Patient’s surname: | Click here to enter text. | Gender: Choose an item. |
| Patient’s forename: | Click here to enter text. |
| Patient’s NHS number:\*MANDATORY\* | Click here to enter text. |
| Contact address: | Click here to enter text. |
| Town or city: | Click here to enter text. | Postcode: | Click here to enter text. |
| Daytime/mobile phone: | Click here to enter text. | Home phone: | Click here to enter text. |
| E-mail address: | Click here to enter text. |
| Does your patient need to communicate in a language or mode other than English?If yes, please specify: | Yes [ ]  No [ ] Click here to enter text. |
| Does your patient need to use a stretcher/wheelchair? | Yes [ ]  No [ ]  | Stretcher [ ]  Wheelchair [ ]  |
| GP Name: | Click here to enter text. |
| GP Practice name and address: | Click here to enter text. |
| Has the patient attended Guy’s and St Thomas’ Hospital before? | Yes [ ]  No [ ]  |

**B. Referrer Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Referrer: | GDP [ ]  | GP [ ]  | Other [ ]  |
| If ‘other’ please specify: | Click here to enter text. |
| Name of referrer: | Click here to enter text. |
| Referrer address: | Click here to enter text. |
| E-mail address: \*MANDATORY\* | Click here to enter text. |
| Telephone number: | Click here to enter text. |

**C. Referral**

|  |  |
| --- | --- |
| Specialist opinion [ ]  | Specialist opinion + Treatment [ ]  |
| Which discipline should see the patient? (please tick ONE only) |
| Multidisciplinary Restorative [ ]  | Periodontology [ ]  | Prosthetics [ ]  |
| Crown/bridge [ ]  | Paediatric Dentistry [ ]  | Implantology [ ]  |
| Salivary Gland [ ]  | Sedation & Special Care [ ]  | Orthodontics [ ]  |
| Oral Medicine [ ]  | Oral & Maxillofacial Surgery [ ]  | Endodontology (For GDP’s Outside London) [ ]  |
| Endodontology (For GDP’s Inside London) – Please ensure you follow the correct process pathway for referring patients, this form can be found on our website <https://www.guysandstthomas.nhs.uk/our-services/dental/referrals.aspx#na>  |
| Reason for referral and relevant medical/dental history |
| Click here to enter text. |
| **URGENT**Yes [ ]  No [ ] *(if yes please tick one or more of the following):* | Reason for urgent referral: |
| Suspected cancer [ ]  | Pain for 48 Hours [ ]  |
| Swelling [ ]  | Trauma [ ]  |
| Other (specify): [ ]  | Click here to enter text. |
| **I confirm that this patient referral meets the relevant acceptance criteria as stated in the current referral guidelines.** [ ] (<https://www.guysandstthomas.nhs.uk/our-services/dental/specialties/specialities.aspx>)  |

**D. Radiographs and supporting documentation**

|  |
| --- |
| Format of radiographs included \*MANDATORY\*. Radiographs MUST be accompanied by the following information: **Patient name, DoB, Side of mouth (Left/Right) and exposure date.***(include any relevant radiographs taken in the past 12 months)* |
| Digital radiographs (in digital format only) [ ] Please email this form and attach digital radiographs to gst-tr.DentalReferrals@nhs.net | Traditional/acetate radiographs [ ] Please print a copy of this form and send with radiographs to the address overleaf. |
| **NB Printed digital radiographs are not of sufficient diagnostic quality and cannot be accepted.** |
| Additional supporting documentation attached [ ]  Please specify: Click here to enter text.Please email this form and attachments to gst-tr.DentalReferrals@nhs.net |

**PLEASE ENSURE THIS FORM IS COMPLETED CORRECTLY AND ANY RADIOGRAPHS AVAILABLE ARE INCLUDED**