**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](mailto: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](mailto: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](mailto:gst-tr.DentalReferrals@nhs.net) | |

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