SOUTH WALES SPECIALIST ORAL SURGERY AND DENTAL IMPLANT CENTRE

New patient referrals

REFERER DETAILS:

CLINICIAN'S NAME _____ DATE OF REFERAL _____

PRACTICE NAME _____

PRACTICE ADDRESS _____

BEST EMAIL CONTACT _____

PATIENT DETAILS:

FULL NAME _____ DoB _____

CONTACT NUMBER(S) _____

EMAIL ADDRESS _____

REFERRAL FOR (please tick most relevant):

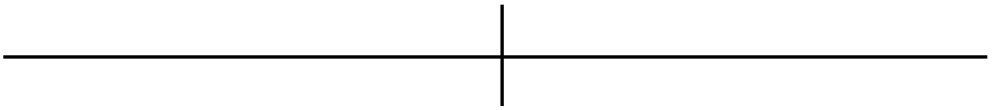
SPECIALIST ORAL SURGERY SERVICES ☐ DENTAL IMPLANT TREATMENT ☐

ORAL & MAXILLOFACIAL SURGERY SERVICES ☐ ORAL MEDICINE SERVICES ☐

TREATMENT / MANAGEMENT REQUIRED (please tick all relevant):

Extraction(s)	☐	Dental implants (surgery only)	☐
Soft Tissue surgery	☐	Dental implants (surgery and restorative)	☐
Bone recontouring	☐	Full arch implant rehabilitation	☐
IV sedation	☐	Implant-retained dentures	☐
Apicectomy	☐	Diagnosis and Treatment as needed	☐
TMJ pain	☐	Facial pain	☐
Skin lesion assessment	☐	Ectopic tooth exposures/removal	☐
Frenectomy	☐	Dental cyst management	☐
Basal Cell Carcinoma?	☐	Red / White patch assessment	☐
Scar revision	☐	Other _____	

Teeth/Site:



Reason for referral: _____

_____

Relevant Medical History: _____

Smoker? Yes / No **Do you suspect the issue may be cancerous?** ☐

Available Radiographs: Periapical ☐ OPG ☐ CBCT(send .dcm files via wetransfer.com) ☐

(*Please send them with referral*)

Please either email form to; consult@specialist.wales

Or post it to us at 3 Ynys Bridge Court, Cardiff, CF15 9SS

Many thanks for your kind referral

For more info, or to submit an electronic referral scan here →

Or visit **www.specialist.wales**