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

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

New Patient Referral Unit

E-mail: [gst-tr.DentalReferrals5@nhs.net](mailto:gst-tr.DentalReferrals5@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>  Undergraduate Dentistry  **\*If your patient is seen on the multidisciplinary restorative or prosthetic clinic and it is determined some aspects of their dental care may be suitable for treatment with our undergraduate department, please indicate below if you consent to your patient being referred onwards for this.**  Yes  No  N.B. This is subject to the undergraduate waiting list being open and the patient being deemed suitable for undergraduate care following an assessment appointment(s). If the patient is not suitable, they will be discharged back to you. This service does not offer specialist care. Please see our website for further information regarding undergraduate treatment <https://www.guysandstthomas.nhs.uk/referral-guide/dental-treatment-undergraduate-students> | | | |
| 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.DentalReferrals5@nhs.net](mailto:gst-tr.DentalReferrals5@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.DentalReferrals5@nhs.net](mailto:gst-tr.DentalReferrals5@nhs.net) | |

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