

Oral Surgery Referral Form

Dr Rikki Dhody BDS (Birmingham) 2009

Special interest in Oral Surgery and Implantology

Patient details

Name	
Date of birth	
Address	
Postcode	
Home telephone number	
Mobile number	
E-mail Address	

Practice details

GDP Name	
Address	
Postcode	
Phone number	
E-mail Address	
Referred by	
Date of Referral	

Medical history and risk factors

Any relevant medical history, please provide as much information as possible including allergies, any history of malignant disease and all medications. Including smoking status and alcohol consumption.

--

Teeth to be extracted (please circle)

Upper Right 8 7 6 5 4 3 2 1 Upper Left 1 2 3 4 5 6 7 8

Lower Right 8 7 6 5 4 3 2 1 Lower Left 1 2 3 4 5 6 7 8

Reason for extraction

Severe pericoronitis		Caries in wisdom tooth	
Recurrent pericoronitis		Caries on adjacent tooth	
Periodontitis		Other (please specify)	
Retained root			
Ectopic tooth			

Wisdom teeth assessment

Angle of impaction	< ----- >		
	Vertical	45 degree angle	Horizontal
Type of impaction	Tooth	Bone	Other
Visibility in mouth	None	Partial	Whole

PA/OPG provided?	YES	NO
Has the patient been informed of the risks?	YES	NO
Has the patient given consent for treatment to commence?	YES	NO
Has the patient been informed of the treatment fee? (£114.00 per extraction)	YES	NO
Will any clinical photographs or radiographs be provided? If so, please send them via email, please see email address below.	YES	NO

Provisional diagnosis	
-----------------------	--

Any other information you feel is relevant, any previous treatments, any mobility/communication/consent issues for the management of this patient?

Signature	
Print	
Date	

Please return form to:

(Post) Oral Surgery Referral, The Dentist, 57 Liskeard Road, Walsall, WS5 3EY
or (Email) info@thedentistwestmidlands.com