Dublin Dental School and Hospital

 ORAL MEDICINE

REFERRAL LETTER

Yes No

[ ] [ ] Concern re Oral / Head & Neck Cancer

Consultant / receiving practitioner and/or specialty clinic

Hospital and Hospital address

DATE:

REFERRAL TO

Department of Oral Medicine

Dublin Dental School and Hospital Lincoln Place,

Dublin 2.

Or email to patient@dental.tcd.ie

PATIENT DETAILS

Patient’s address

Surname

Forename(s) Previous Surname

Telephone no.

Sex

M

F

Or Contact

Age

Date of Birth

E-Mail

|  |
| --- |
|  |

|  |
| --- |
|  |

frf

|  |
| --- |
|  |

[ ] [ ]

|  |
| --- |
|  |
|  |
|  |

REFERRING PRACTITIONER DETAILS

Practice address

Name

Email address Telephone no.

|  |
| --- |
|  |

|  |
| --- |
|  |
|  |

REGISTERED GP DETAILS (Medicine)

Practice address

Name

Email address Telephone no.

CLINICAL INFORMATION

**Please complete all sections to facilitate appropriate triage of your referral.  Proformas with insufficient detail will be returned for completion**

|  |
| --- |
| **History of presenting complaint/ examination findings/ investigation results** |
|  |
| **Reason for referral** |
|  |
| **Past Medical History** |
|  |
| **Current and recent medication** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Clinical warnings (*e.g. allergies, blood-borne, viruses)*** |  |  | Smoking status | Alcohol consumption |
|  | No per day | Duration |  |  |
|  |  |  |  |  |
|  |  | Ever Smoked | Yes [ ]  | No [ ]  |
|  |  |  |  |  |
| Additional relevant information |
| Social History (eg. Employment) | Special Needs (eg. Wheel Chair)  |  | PhobiaYes [ ]  | No [ ]  |

Please provide quality colour photographs in cases of oral mucosal disease. Photographs of the oral mucosa taken with intra-oral cameras are not helpful.

Triage Stamp

Date

Signature of referring doctor (or other professional)

(Legible Please)

 **Please note incomplete referrals will be returned**