

Oral/Maxillofacial Surgery/Medicine Referral Form

Dear Doctor/Dentist,

This form should be used for the conditions outlined below. Please note that this form must not be used for the referral of exodontia and/or apical surgery.

1. Recurrent Oral Ulceration
2. Lumps, Swellings, Cysts or other Pathology of the Oral Cavity
3. Head & Neck Lumps, Cysts, Swellings
4. Lymphadenopathy
5. White &/or Red Patches
6. Oral Submucous Fibrosis
7. Oro-Facial Pigmented Lesions
8. Facial Pain
9. Burning Mouth
10. Minor &/or Major Salivary Gland Disease
11. Halitosis
12. Xerostomia
13. Infection of the Oral Cavity
14. Oral Manifestation of Systemic Disease
15. Paraesthesia/Anaesthesia of the Oro-Facial region
16. Oral & Maxillofacial Trauma
17. Facial Deformity
18. TMJ Pain and/or problems
19. Surgical Orthodontics
20. Other – Please specify

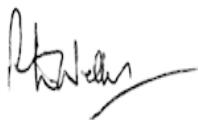
A full Clinical History **MUST** be included, for example the duration of the condition, the **EXACT** site of the lesion, size, other signs and symptoms etc.

It is essential that all relevant information is noted on the referral form and that all parts of the form are filled in.

Any enclosures such as Photos and Radiographs will help to save time for your patient.

SUSPECTED CANCEROUS LESIONS SHOULD BE REFERRED VIA THE USUAL URGENT 2 WEEK REFERRAL SYSTEM.

Kind regards,



Mr Peter Weller
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BDS, FDS RCPS, MBBS, FRCS



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Specialist Oral Surgeon
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