University Hospitals Bristol NHS
NHS Foundation Trust

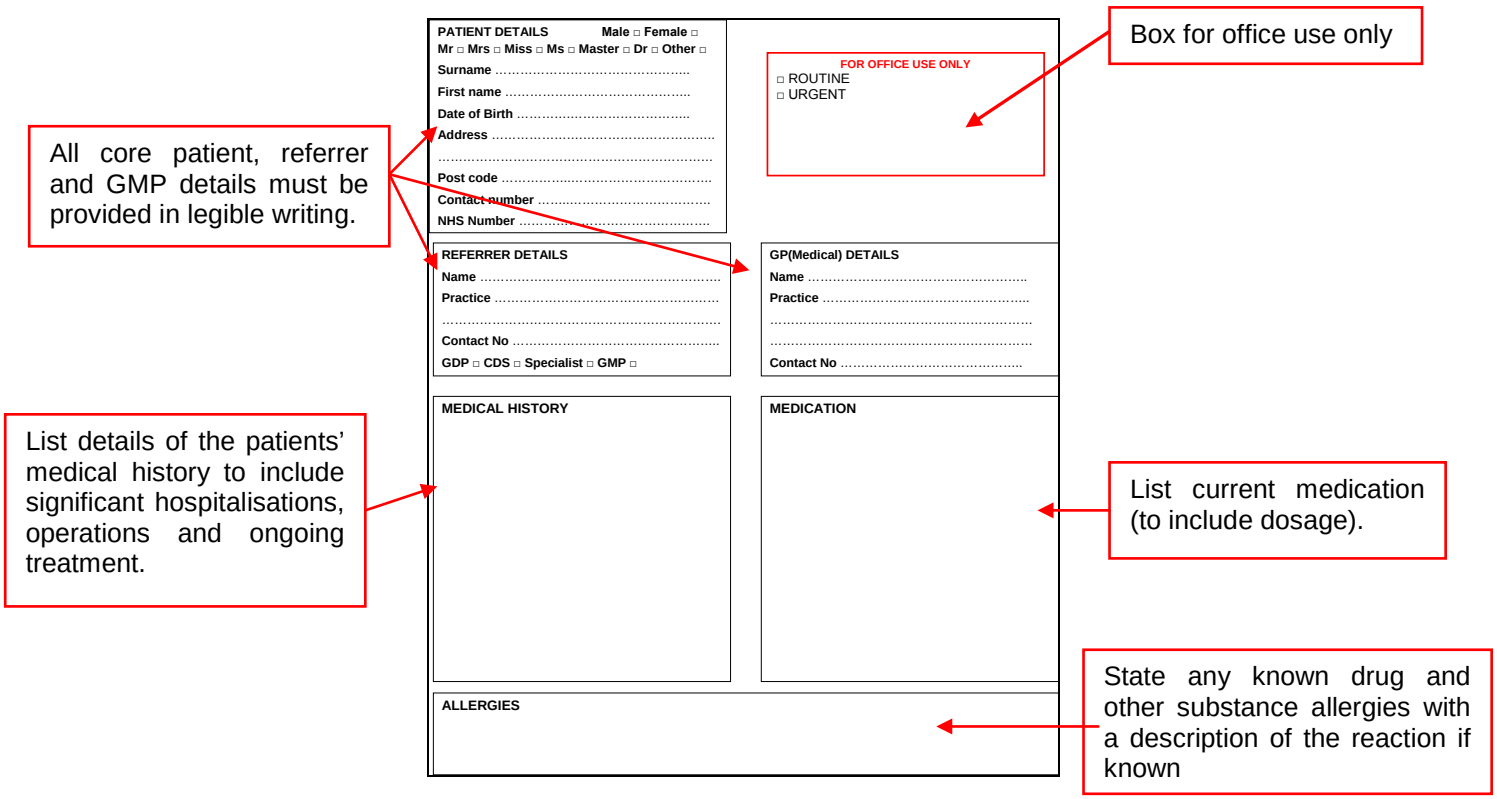
ALTERATION TO ORAL SURGERY REFERRALS

Audits into the quality of referrals received by the Oral Surgery department have shown improvements since the introduction of the standardised referral proformas. In 2008 just 5% of referrals received contained appropriate data to facilitate prioritising patient consultation and treatment, this increased to **41%** by 2012. There is still room for improvement, particularly in the area of radiographic imaging. An audit carried out throughout March 2013 revealed that just **36%** of referrals included **diagnostically acceptable** radiographs. In order for a general dental practitioner to accurately assess the patient, and decide that their patients need to be referred to the Oral Surgery department, a diagnostically acceptable radiograph must be taken. In line with the principles of radiation protection to prevent unnecessary radiographic exposure to patients[1,2] we ask that referrals include the radiograph taken by the referring dentist.

There exists the possibility of streamlining services so that if a full and detailed referral was made, patients could be booked directly for treatment appointments, without the need for assessment first. It would give us the opportunity to place patients into the most suitable treatment slots, performed by the most appropriate person, whether that is by staff or by students. This would allow patients to access treatment more quickly, increase efficiency and reduce waiting times. Alterations to the Oral Surgery referral forms have been made to enable this target to be achieved.

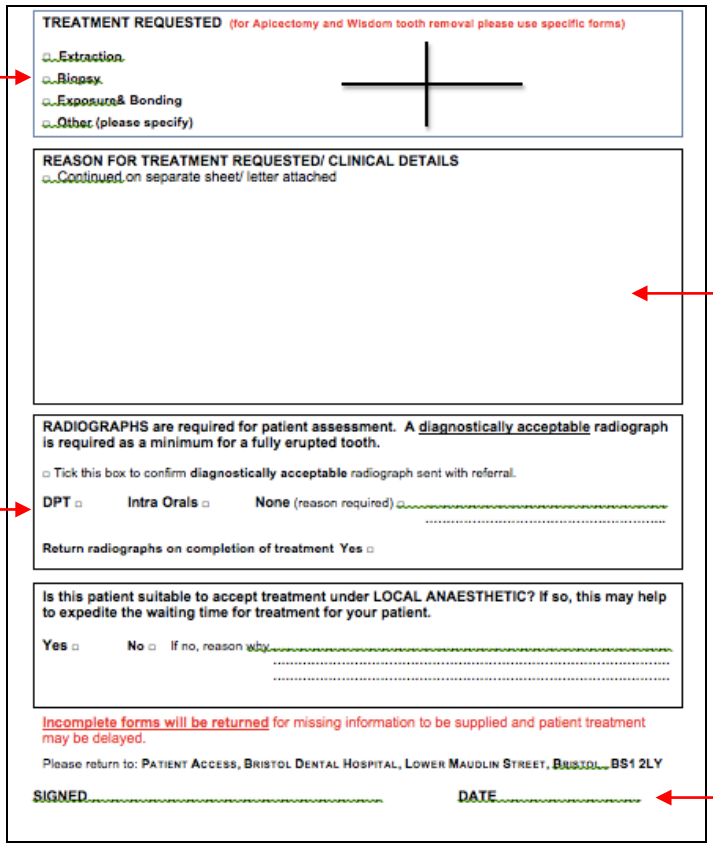
ALL SECTIONS OF THE FORM MUST BE COMPLETED OTHERWISE THE REFERRAL WILL BE RETURNED REQUESTING FURTHER INFORMATION.

Page 1 GENERIC FRONT SHEET



General Oral Surgery Referral

Tick the appropriate box and detail the tooth/ teeth on the charting. If the treatment required does not fit into any of the above categories then detail in the box



TREATMENT REQUESTED (for Apicectomy and Wisdom tooth removal please use specific forms)

- Extraction
- Biopsy
- Exposure& Bonding
- Other (please specify)

REASON FOR TREATMENT REQUESTED/ CLINICAL DETAILS

Continued on separate sheet/ letter attached

RADIOGRAPHS are required for patient assessment. A diagnostically acceptable radiograph is required as a minimum for a fully erupted tooth.

Tick this box to confirm diagnostically acceptable radiograph sent with referral.

DPT Intra Orals None (reason required)

Return radiographs on completion of treatment Yes

Is this patient suitable to accept treatment under LOCAL ANAESTHETIC? If so, this may help to expedite the waiting time for treatment for your patient.

Yes No If no, reason why

Incomplete forms will be returned for missing information to be supplied and patient treatment may be delayed.

Please return to: PATIENT ACCESS, BRISTOL DENTAL HOSPITAL, LOWER MAUDLIN STREET, BRISTOL, BS1 2LY

SIGNED DATE

Please provide:

- Reasoning for above treatment request
- Significant history including previous consultations for the condition
- Active problems
- Clinical information
- Preliminary investigations and results
- Relevant patient factors (eg. Phobic, social factors)
- Modality (LA/ GA/ IV Sedation)

Radiographs or copies should be included with every referral unless inappropriate (eg. biopsy request).

The radiograph must be of **diagnostically acceptable** quality otherwise the form may be returned to you, delaying patient treatment.

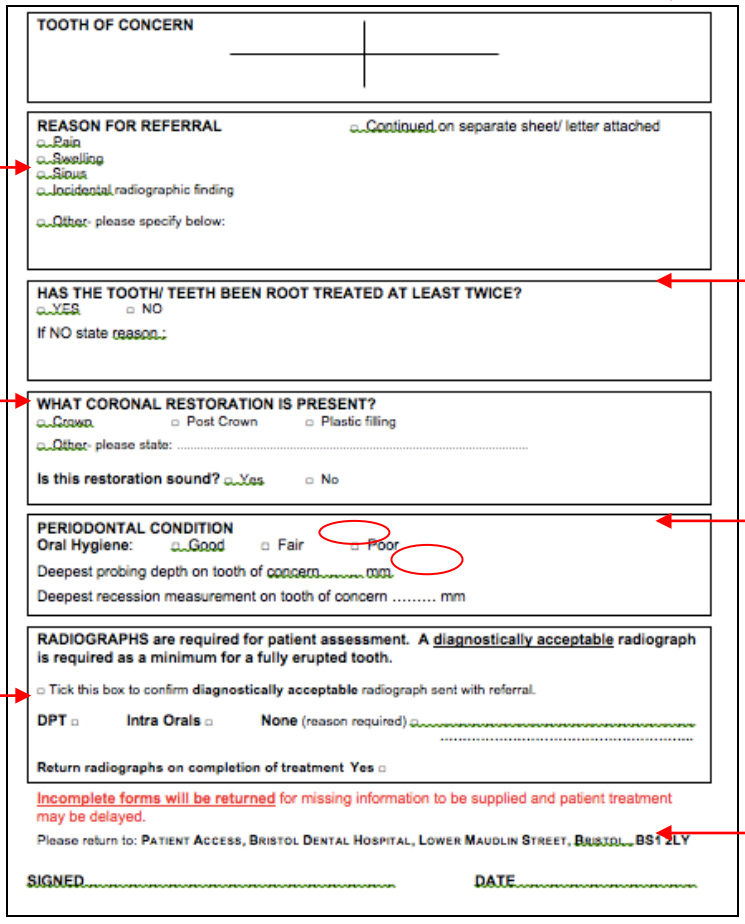
Please sign and date

Apical Surgery Referral

Please explain reason for tooth requiring apicectomy.
Any additional information can be attached on extra sheets secured to the referral proforma.

Please indicate what type of coronal restoration is present and comment on soundness.

Diagnostically acceptable radiographs or copies should be included with every referral. Failure to include a radiograph may result in the return of the form and delay in patient treatment.



TOOTH OF CONCERN

REASON FOR REFERRAL Continued on separate sheet/ letter attached

- Pain
- Swelling
- Sinus
- Incidental radiographic finding
- Other- please specify below:

HAS THE TOOTH/ TEETH BEEN ROOT TREATED AT LEAST TWICE?

YES NO

If NO state reason:

WHAT CORONAL RESTORATION IS PRESENT?

Crown Post Crown Plastic filling

Other- please state:

Is this restoration sound? Yes No

PERIODONTAL CONDITION

Oral Hygiene: Good Fair Poor

Deepest probing depth on tooth of concern ..... mm

Deepest recession measurement on tooth of concern ..... mm

RADIOGRAPHS are required for patient assessment. A diagnostically acceptable radiograph is required as a minimum for a fully erupted tooth.

Tick this box to confirm diagnostically acceptable radiograph sent with referral.

DPT Intra Orals None (reason required)

Return radiographs on completion of treatment Yes

Incomplete forms will be returned for missing information to be supplied and patient treatment may be delayed.

Please return to: PATIENT ACCESS, BRISTOL DENTAL HOSPITAL, LOWER MAUDLIN STREET, BRISTOL, BS1 2LY

SIGNED DATE

Please detail the tooth requiring assessment for apicectomy.

An endodontic history of the tooth should be detailed

Assessment of the periodontal tissues and oral hygiene must be recorded. Probing depths & recession must be entered as requested.

Please sign and date

Wisdom Tooth Referral

Please tick the tooth/ teeth requiring assessment adjacent to the appropriate indication:

Tooth to be removed	UR8	UL8	LR8	LL8
Second or subsequent episodes of Pericoronitis				
Unrestorable caries in tooth/ adjacent teeth		✔		
Untreatable pulpal or periapical pathology				
Abscess				
Root resorption in tooth/ adjacent teeth				
Fracture of tooth				
Cyst				
Periodontal disease affecting tooth/ adjacent teeth				
Tooth causing traumatic occlusion				
Previous attempted extraction				
Other - please specify				

RADIOGRAPHS are required for patient assessment.

If tooth is fully erupted **a diagnostically acceptable radiograph is required.**

If tooth is partially erupted, **a radiograph which justifies referral**, will be accepted (e.g. caries demonstrated in lower 7.)

If no radiograph enclosed, please give reason why not.....

Return radiographs on completion of treatment Yes □

Incomplete forms will be returned for missing information to be supplied and patient treatment may be delayed.

Please return to: PATIENT ACCESS, BRISTOL DENTAL HOSPITAL, LOWER MAUDLIN STREET, BRISTOL, BS1 2LY

SIGNED..... DATE.....

In the appropriate box please tick which tooth/ teeth require assessment and the indication for removal.

Eg. Carious UL8

For further information on the assessment of wisdom teeth for removal please see NICE guidelines.
www.**nice**.org.uk

Radiographs or copies should be included with every referral. A **diagnostically acceptable** radiograph is required for a fully erupted tooth. A radiograph which **justifies referral** is acceptable for a partially erupted tooth.
A reason must be given why no radiograph is included, otherwise the form may be returned, delaying patient treatment.

Please sign and date

Copies of the new referral forms are attached and additional copies will be available for download on the University Hospitals Bristol website:

http://www.uhbristol.nhs.uk/referral-forms

Thank you for your cooperation.

Mr S. J. Thomas
Consultant Maxillofacial Surgeon

References

1. SIGN 31 'Report on recommended referral document' Nov 1998
2. Guidance Notes for Dental Practitioners on Safe use of Xray Equipment. National Radiological Protection Board 2001.