Dublin
Dental School
and Hospital

ORAL AND MAXILLOFACIAL SURGERY REFERRAL LETTER

REFERRAL TO

DATE:

Consultant / receiving practitioner and/or specialty clinic

Hospital and Hospital address

Dublin Dental School and Hospital
Lincoln Place,
Dublin 2.

Concern Re Oral Cancer / Head and Neck Cancer — Yes / No

Concern Re Salivary Gland Disease *eg: Parotid Lump* — Yes / No

PATIENT DETAILS

Surname

Forename(s)

Previous Surname

Title — Mr / Mrs / Miss / Ms / Other

Sex — M / F

Age

Date of Birth

Patient's address

Telephone no.

Or Contact

E-Mail

REFERRING PRACTITIONER DETAILS

Name

Email address

Telephone no.

Fax no.

Practice address

REGISTERED GP DETAILS (Medicine)

Name

Email address

Telephone no.

Fax no.

Practice address

CLINICAL INFORMATION

History of presenting complaint/ examination findings/ investigation results

Reason for referral

Past Medical History

Current and recent medication

1	dose	5	dose
2	dose	6	dose
3	dose	7	dose
4	dose	8	dose

Clinical warnings (*e.g. allergies, blood-borne, viruses)*

Smoking status

No. per day

Duration

Ever Smoked
(Y / N)

Alcohol consumption

Units per week

Additional relevant information

Social History (eg. Employment)

Special Needs (eg. Wheel Chair)

Phobia (Yes / No)

Other

Signature of referring doctor (or other professional)
(Legible Please)

Date

HOSPITAL TO COMPLETE

Consultant/Specialist

Date Received

Date appointment

URGENT ASAP SOON ROUTINE

Investigations Required

Previous DDSH Chart Required