NHS
Gloucestershire Hospitals
NHS Foundation Trust

| | |
|---|---|
| **Name:** | |
| **Date of Birth:** | DD / MM / YYYY |
| **MRN Number:** | |
| **NHS Number:** | |
| (OR AFFIX HOSPITAL LABEL HERE) | |

# Third Molar Removal Referral Form

**www.gloshospitals.nhs.uk/glosmaxfax**

**Patients referred for consideration for the surgical removal of third molars MUST satisfy one or more of the National Institute for Health & Care Excellence (NICE) indications for treatment. For details please visit www.nice.org.uk/Guidance/TA1.**

**Please tick to confirm guidance satisfied [ ] (referrals rejected otherwise)**

**Please advise your patients that they may be seen at Cirencester, Cheltenham General or Gloucestershire Royal Hospitals**

| **Patient details** | |
|---|---|
| Name | D.O.B |
| Gender Male ❑ Female ❑ | NHS No (Mandatory) |
| Address<br><br>Postcode | |
| Home telephone | Mobile telephone |
| All medical conditions, allergies/reactions and medications | |

**Treatment requested: State tooth / teeth for removal and reason**

| **Tooth** | **Reason** |
|---|---|
| Upper Right 8 [ ] | Pericoronitis ❑ Caries ❑ Other ❑ |
| Upper Left 8 [ ] | Pericoronitis ❑ Caries ❑ Other ❑ |
| Lower Left 8 [ ] | Pericoronitis ❑ Caries ❑ Other ❑ |
| Lower Right 8 [ ] | Pericoronitis ❑ Caries ❑ Other ❑ |

**Radiographs** **www.gloshospital.nhs.uk/glosmaxfax/xrays**

Good quality radiographs MUST accompany this referral in accordance with the specification detailed on our website above. If the radiographs are of insufficient quality, or are not enclosed, we will regretfully return the referral to you until such time as we are in receipt of a suitable radiograph.

| | |
|---|---|
| Name of referring dentist (print name) | Date<br>DD / MM / YYYY |
| Address of referring dentist | |