

MAXILLOFACIAL UNIT THIRD MOLAR REFERRAL FORM

This form must be used for all patients being referred for the extraction of third molars. All sections must be completed.

Practitioner details Name: Address: Post code: Telephone: Fax:	Patient details Name: Address: Post code: Date of Birth: Telephone: Fax:
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1. Please indicate why you are referring this patient for third molar extraction.
(please tick all relevant boxes)

Overt or previous history of infection including pericoronitis	<input type="checkbox"/>
Unrestorable caries	<input type="checkbox"/>
Non-treatable pulpal and/or periapical pathology	<input type="checkbox"/>
Cellulitis, abscess and osteomyelitis	<input type="checkbox"/>
Periodontal disease	<input type="checkbox"/>
Orthodontic abnormalities	<input type="checkbox"/>
Facilitation of restorative treatment including provision of prosthesis	<input type="checkbox"/>
Internal/external resorption of tooth or adjacent teeth	<input type="checkbox"/>
Pain directly related to third molar	<input type="checkbox"/>
Tooth in line of bony fracture or impeding trauma management	<input type="checkbox"/>
Fracture of tooth	<input type="checkbox"/>
Disease of follicle including cyst/tumour	<input type="checkbox"/>
Tooth/teeth impeding orthognathic surgery or reconstructive jaw surgery	<input type="checkbox"/>
Tooth involved in/ within field of tumour resection	<input type="checkbox"/>
Satisfactory tooth for use as donor for transplantation	<input type="checkbox"/>
Prophylactic removal in presence of specific medical and surgical conditions	<input type="checkbox"/>
Other - specify	<input type="checkbox"/>
Advice only	<input type="checkbox"/>

2. Full description of clinical problem

For maxillofacial unit use only	Yes	No
Referral complies with N.I.C.E guideline criteria	<input type="checkbox"/>	<input type="checkbox"/>
Patient accepted for third molar extraction	<input type="checkbox"/>	<input type="checkbox"/>
Comments		