**Intermediate Tier (Tier 2)**

**IMMEDIATE POST-OPERATIVE REFERRAL – FAILED EXTRACTIONS**

**Patient’s Aged 16 Years Plus**

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| **THIS FORM SHOULD ONLY BE COMPLETED FOLLOWING A FAILED EXTRACTION AND IMMEDIATE ACTION IS REQUIRED FOR ENTRY INTO INTERMEDIATE TIER**  **YOU SHOULD NOT USE THIS FORM TO MAKE A STANDARD REFERRAL TO INTERMEDIATE TIER OR MAXILLOFACIAL SURGERY**  **IN THE FIRST INSTANCE, PRACTITIONER IS TO MAKE CONTACT WITH Marie Smith, Dental Administration Office, Royal Alexandra Hospital, Rhyl, via telephone – 03000 854823 or email** [BCU.NWCDSIntermediateTier@wales.nhs.uk](about:blank) **prior to completion of this proforma**.  **PRIOR TO SUBMISSION OF THIS FORM PLEASE ENSURE THAT YOU HAVE ENCRYPTED IT WITH A STRONG PASSWORD AND NOTIFIED THIS TO** [BCU.NWCDSIntermediateTier@wales.nhs.uk](about:blank) **OR USED SECURE FILE SHARING SOFTWARE**  I confirm that I have understood the referral criteria and my patient understands the need for the referral and consents to be referred: **PRACTITIONER** **TO CONFIRM**: |

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| **Patient’s title and full name:** | **Age:** | **Date of birth:** |
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| **Patient’s Full address, including postcode:** | **Best daytime contact number:** | |
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| **Referrer’s name:** | **Practice name:** | | **Practice address:** |
|  |  | |  |
| **Practice telephone number** | |  | |

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| **Main reason for referral is for completion of failed extraction(s). Please provide details of the procedure, i.e. patient inability to cope (sedation or GA is not required), limited mouth opening, unsuccessful anaesthesia etc.,):** |
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| **\*\*\*You will be required to provide a pre and post-operative x-ray and attach to this document**  **otherwise the referral will be rejected\*\*\*** |

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| **In order to determine the referral suitability, please answer the following questions:** | | **Details** |
| Patient is willing to travel? | yes / no: |  |
| Patient agrees to attend the appointment? | Yes / no: |  |
| Is the patient taking Warfarin or DOACs | Yes / no: |  |
| Is there any significant medical history we should know about | Yes / no: |  |
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**Referral to Intermediate Tier Failed Extraction Emergency Service Checklist**

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| **Prior to referral please ensure all questions have been answered** | | | | **Tick when complete:** |
| The patient requires an urgent appointment for a failed extraction undertaken in the last 48 hours due to the following reason: | | | | |
| * Patient inability to cope, sedation or GA not required | | | |  |
| * Limited mouth opening | | | |  |
| * Unsuccessful anaesthesia | | | |  |
| * numbers of roots or abnormal roots – please state: | | | |  |
| * root canal treated tooth at risk of fracture | | | |  |
| * Broken to gum level requiring surgical extraction beyond practitioner skill scope | | | |  |
| The patient is aged 16 years or over | | | |  |
| You have made contact with Marie Smith on 03000 854823 or email: [BCU.NWCDSIntermediateTier@wales.nhs.uk](about:blank) | | | |  |
| You have encrypted with a strong password and informed [BCU.NWCDSIntermediateTier@wales.nhs.uk](about:blank) of this OR used secure file sharing software | | | |  |
| All patient details including phone number are provided | | | |  |
| The patient understands the reasons and has given consent for the referral | | | |  |
| Patient is willing to travel to (please tick) Wrexham CDS Clinic |  | Buckley CDS Clinic |  |  |
| Patient agrees to attend the appointment? | | | |  |
| You have stated if the patient is taking Warfarin or DOACs | | | |  |
| You have stated if the patient is taking steroids | | | |  |
| You have stated if there is any significant medical history relevant to dental extractions | | | |  |
| You have made available pre- and post-extraction attempt radiographs of appropriate quality and attached them to this referral also | | | |  |