

Wessex Area TMJ Disorders Referral Form

(Version Nov 2018 - Form for Electronic Filling In - Page 1 of 2)



REFERRAL FOR TMJ Disorders

1. **Please complete all sections.** Incomplete forms may be returned.
2. **This version of the form can be filled in digitally on a PC, and then printed.** Separate versions of this form designed to integrate with Carestream R4 or SoE appear on the Solent Website <http://www.solent.nhs.uk/dental> , and the Hampshire LDC website <http://hiowldc.org/> . Other versions of this form are also available there. This form is protected. It should allow you to type only in the grey boxes. The grey colour will not appear when printing. To modify the template, you may need to unprotect it, via the 'Restrict Editing' feature of MSWord. Password is 1234.
3. **NB. Please do not refer without reading the referral criteria.** The TMJ Disorders Referral Criteria can be found online at the above links.
4. **Please post the completed form to your local Oral and Maxillofacial Department (addresses at the end of this form).** Do NOT send these to the Minor Oral Surgery Referral Centre, Southampton.
5. For the **2 WEEK CANCER FAST TRACK** referrals, use the forms specific to the appropriate local hospital (See the above links and the Referral Matrix for further information).

SECTION ONE – PATIENT DETAILS

Name	First name(s)	Surname(s)
Gender		Title
Date of Birth		dd/mm/yyyy
NHS No (if known)		
Address		
Post Code		
Landline:		
Mobile:		

SECTION TWO – DETAILS OF REFERRER

Referrer Name	
GDC Number	
Signature	
Date	
Practice Stamp or Address:	
Practice ODS Code	
Practice Phone	
Practice NHS.net email	

- Please tick to confirm the referrer has read the appropriate NHS England South (Wessex) Referral Criteria and is confident that the patient meets referral conditions.
- Please tick to confirm agreement by practice contract holder for this referral to be made.
- Please tick to confirm that referrer has checked that the patient's address, contact and GP details, are correct and up to date.

SECTION THREE – DETAILS OF GENERAL MEDICAL PRACTITIONER (G.P)

Please Note: This information is **mandatory**. If this section is incomplete the referral will be returned to the referrer concerned.

GP Name and Address	
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SECTION FOUR – MEDICAL HISTORY

(Please attach MH form and drug list if available)

Medical conditions	
Current medication	
Allergies	
Smoking / Alcohol	
Disability	

Please repeat from page 1:

Patient Name:	First name(s)	Surname	DOB:	
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SECTION FIVE – REASON FOR REFERRAL (please tick, cross or circle relevant answers)

Is the patient edentulous?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How long has the specific problem been present?		
Is the pain worse on waking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does it increase in severity during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this a severe acute episode?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient have associated limited mouth opening?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tenderness of TMJ on palpation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tenderness of muscles of mastication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deviation on opening?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Deviation on closing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of bruxism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discomfort on opening?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Discomfort on closing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking or locking on opening?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking or locking on closing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of jaw dislocation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of previous trauma to jaw?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient received verbal and written TMJ dysfunction patient information? Give details below	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient received any specific advice/treatment for the problem? Give details below	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the patient been given any exercises to do?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Previous provision of a bite raising appliance	<input type="checkbox"/> upper	<input type="checkbox"/> lower
Has the patient been seen by other medical specialists? Give details below	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<u>Details to any of the questions above:</u>		
Any parafunctional habits relevant to the symptoms, and whether these are on-going or ceased? E.g. chewing gum, nail biting, bruxism, clenching.		
Outcomes of any treatment provided Review would normally be over a period of no less than six months.		
Any other information		

PLEASE SEND THIS REFERRAL TO ONE OF THE LOCATIONS BELOW: (Please tick, cross or circle one)

<input type="checkbox"/> Basingstoke & North Hampshire NHS Foundation Trust, Aldermaston Road, Basingstoke. RG24 9NA
<input type="checkbox"/> Royal Bournemouth & Christchurch Hospital, Castle Lane East, Bournemouth, Dorset, BH7 7DW
<input type="checkbox"/> Dorset County Hospital, Williams Avenue, Dorchester, Dorset, DT1 2JY
<input type="checkbox"/> Frimley Park Hospital, Portsmouth Road, Frimley, Surrey, GU16 7JU
<input type="checkbox"/> St Marys Hospital, Parkhurst Road, Isle of Wight, PO30 5TG
<input type="checkbox"/> Poole Hospital NHS Foundation Trust, Longfleet Road, Poole, Dorset, BH15 2JB
<input type="checkbox"/> Queen Alexandra Hospital, Southwick Hill Road, Cosham, Portsmouth, PO6 3LY
<input type="checkbox"/> The Royal Surrey County Hospital Foundation Trust, Egerton Road, Guilford, Surrey, GU2 7XX
<input type="checkbox"/> Salisbury Hospital, Odstock Road, Salisbury, Wiltshire, SP2 8BJ
<input type="checkbox"/> Southampton University Hospital Trust, Tremona Road, Southampton, Hampshire, SO16 6YD
<input type="checkbox"/> Winchester & Eastleigh Healthcare NHS Trust, Romsey Road, Winchester, Hampshire, SO22 5DG