Internal referral form for OFP service,

Office use only:

Copy of form in notes:

All results/reports available?

Referral and results scanned and sent to INPUT

Dental Institute, KCH.

| Kings College Hospital & Guys & St. Thomas’ Hospital Joint Orofacial Pain MDT referal proforma Held at INPUT Pain Unit – Gassiot House, St Thomas’ on the first Tuesday of the month. | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please complete and give to Emmy Simmons or email to: esimmons1@nhs.net | | | | | | | | |
| Date of Referral: | Clinic: | | | Referring clinician: | | | | |
| Patient Name: | | | | DOB: | | | | |
| Patient Address & postcode: | | | | | | | | |
| Patient phone number: | | | | | Mobile: | | | |
|  | | | | | | | | |
| GP name: | | | | | | GP Telephone: | | |
| GP Address & postcode: | | | | | | | | |
|  | | | | | | | | |
| History of complaint: | | | | | | | | |
|  | | | | | | | | |
| Specific questions for MDT: | | | | | | | | |
|  | | | | | | | | |
| Medical History including medication list: | |  | Results you would like to be sent (please circle):  Bloods  MRI  CBCT  Radiographs  Last letters to be sent (please note dates letters written): | | | |  | Additional Information: |
| Print Name: |
| Date: |