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|  | **Dental Services Referral Form- ORAL MAXILLOFACIAL SURGERY**  **Date:** |

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| **DRN/UR** | **Title:** | **Surname** | **Given name** | **Date of birth:** |
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| **Street address** | **Suburb** | **Postcode** |
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| **Name of Residential Facility (if applicable)** | | |
| Room: | | |

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| **Phone - Home:** |  | **Mobile:** |  | **Work:** |  |

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| **Country of birth:** |  | **Cultural background:** |  |

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| **Needs interpreter:** | **Yes  No** | **Language:** |  |
| **Indigenous status:** | : | | |
| **Priority access:** |  | | |

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| **Concession Card type:** |  | | |
| **Concession Card No:** |  | **Expiry date:** |  |
| **Medicare Card:** | Patient no. | | |
| **Medicare Card No:** |  | **Expiry date:** |  |

**For Under 18 patients:**

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| **Parent/Guardian name(s):** |  | | |
| **Relationship to patient:** |  | **Phone:** |  |
| **School:** |  | | |

**For patients unable to provide self-consent:**

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| **Person Responsible name:** |  | | |
| **Relationship to patient:** |  | **Phone:** |  |
| **Address:** |  | | |

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| **ORAL MAXILLOFACIAL SURGERY UNIT - OVERVIEW** |
| The OMS Unit provides specialist level diagnosis & management of oral & dentoalveolar conditions. The Unit also provides advice to referring practitioners for treatments they can provide to patients under their care. The Unit works closely with OMS services situated within tertiary hospital settings across Melbourne. |
| **SPECIALIST-IN-TRAINING TEACHING CASES – Consideration of Complex Cases** |
| RDHM is a teaching hospital and therefore a limited number of complex cases **may** be accepted for postgraduate training purposes. Training cases should align with the value-based health care principles in a public dentistry setting.  **Note:** There is no direct referral process to Postgraduate teaching programs. Case selection and acceptance will be considered separately for specialist-in-training. This patient ***does not wish*** to be managed by Specialists-in-training. Time to treatment may be delayed if opted not to be seen by Specialists-in-training. |
| **EMERGENCY OMS PATIENT** |
| Patients with neck swelling, difficulty swallowing &/or limited mouth opening should be referred directly to the nearest emergency department of a medical hospital (Please call the medical hospital & ask to speak to the OMS Registrar on call **before** referring patients) |
| **GUIDANCE FOR REFERRING EMERGENCY OMS PATIENT** |
| Patients with space infections of dentoalveolar aetiology with no systemic symptoms and adequate mouth opening are to be directed to attend Primary Care or ED services at RDHM.  The referring practitioner is to contact RDHM OMS Unit on **(03) 9341 1277** to ensure appropriateness of referral & ascertain the ability of the clinic to coordinate care on the day.  Conditions that may require urgent referral management include: (Urgency 1)   * Suspected malignancy * Cysts and tumours of the jaw with concerning signs and/or symptoms * Patients suspected to have MRONJ * Tooth or roots pushed into a sinus or other space * Nerve injuries   Referrers should clearly mark patients with acute symptoms on the RDHM OMS Referral Form as **URGENT**, indicating reasons for urgent attention. The patient must be provided with this completed Referral Form and any available radiographs. They are to check-in at the RDHM ground floor and follow directions to the OMS reception after an appointment has been organised. Due to demand, it may not be possible to provide the care proposed for a particular patient on the same day. This particularly applies to patients requiring general anaesthesia.  **Prior phone notification and confirmation of the receipt of the referral is essential.** |
| **CLINICAL CRITERIA FOR REFERRAL** |
| Impacted teeth with the following presentations: (inc. 8’s, supernumerary and other teeth)   * Recurrent pericoronitis not responding to conservative management * Impacted teeth with associated pathology * Impacted teeth requiring removal as part of a comprehensive care plan   Anticipated difficult surgical extraction for teeth  Private orthodontic patients requiring treatment planning for the management of jaw deformities  Cysts and tumours of the jaw  Other soft tissue lesions of the oral cavity  Dento-alveolar surgery for patients with complex medical needs (e.g. immunosuppressed, previous head & neck radiotherapy)  Patients taking bisphosphonates or antiresorptive medication for > 4 years, who are diabetic or immunocompromised, taking corticosteroids, with neoplastic disease or requiring multiple sequential extractions or surgical extractions. |

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| **EXCLUSION CRITERIA** |
| * Patients <14 years of age are to be referred to Paediatric Dentistry Department * Patients requiring combined orthodontic & surgical management of jaw deformities are to be referred to Specialist Orthodontic Department * There is no longer an external referral process for implant therapy via OMS unit. Please consider a referral to the Specialist Prosthodontic Department |
| **PREREQUISTES FOR REFFERAL** |
| An updated medical questionnaire  Good quality OPG or diagnostic-quality imaging  An indication of how the referral fits in the overall dental treatment plan (eg urgent referral for the removal of wisdom teeth as patient is about to start cancer therapy) |
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| **REASON FOR REFERRAL** |
| Examination and treatment              Opinion only                Telehealth |
| **Referral Urgency** |
| Referral indication of Urgency for Specialist Care (see Appendix to Referral to the Royal Dental Hospital of Melbourne Procedure)  Urgency 1  Urgency 2  Urgency 3 |
| **Patient’s / Responsible person’s main concern / dental needs (in their own words):** |
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| **Details for the referral** |
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| **Provisional or Definitive Diagnosis** |
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| **Briefly describe how the service requested fits in your overall treatment plan.** |
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| **Summary of medical history:** |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **Notable issues** | **Summary information** | | | | **Details attached** | | Physical or sensory impairment | Sight | Hearing | Physical | Nil known |  | | Intellectual impairment | Learning | Behaviour | Communication | Nil known |  | | Falls Risk / Pressure Ulcers | Falls Risk | Pressure Injuries | | Nil known |  | | Medications | Prescribed | Self-administered | | Nil known |  | | Allergies / ADR | Allergy | Adverse Drug Reaction | | Nil known |  | | Other significant risks | Yes | No | | Nil known |  | | *Details of other risks:* | | | | | | |

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| **Does this patient require support services such as a Social Worker?** | |
| No  Yes | If yes, please provide a brief overview of support services required: |

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| **Referring Clinician details:** | | **Phone:** | **Clinical Supervisor** |
| Or completed on behalf of | |  | Approval provided by: |
|  | | | For Students: |
| ***Community Dental Clinic referring:*** |  | | |
| ***Community Dental Clinic mailing address:*** |  | | |
| ***Referring Clinician email:*** |  | | |

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| **Ongoing care required by referring clinician** |
| By submitting this referral, I on behalf of the referring clinic, agree to:  Ensure that appropriate symptomatic relief is provided to the patients as required  Overall general care to this patient while on the waiting list |