**TMJ Referral Form**

**Email to:** **gwh.omfs@nhs.net**

The Faculty of Dental Surgery (RCS Eng) published detailed guidance in 2013 regarding the primary care management of Temporomandibular Discorders. It is clear from this guidance that secondary care intervention is only needed in a small number of cases.

<https://www.rcseng.ac.uk/dental-faculties/fds/publications-guidelines/clinical-guidelines/>

**Please tick to confirm guidance satisfied ☐ (referrals rejected otherwise)**

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| As a result we will now only accept TMJ referrals when there are the following (please tick) |
| Intractable TMJ pain or persistent closed lock (less than 20mm trismus) that has not responded in 3 months to physio / jaw exercise, analgesia and a BRA / splint if indicated by the above guidance | ☐ |
| Diagnostic doubt (see ‘Key Fact’ section of above document) | ☐ |

**Reason for referral** Description of problem, provisional diagnosis and treatment provided in primary care:

Click to enter text.

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| **Patient details** |
| **Patient Name**: Click to enter text. | Date of birth: Click to enter a date. |
| **Gender** Male ☐ Female ☐ | **NHS No** (Mandatory) Click to enter text.**GWH No** (if known) Click to enter text. |
| **Patient Address:**  Click to enter text.**Postcode:** Click to enter text. |
| **Home telephone**: Click to enter number | **Mobile telephone**: Click to enter number |
|  **Medical History.** Include any medical conditions, allergies/reactions and medications, and relevant social history:Click to enter text. |

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| **Confirmation of consent:** I confirm I have discussed with the patient the nature of the referral ☐I confirm that I have assessed the treatment required is beyond my skill/competence ☐I understand that incomplete or inappropriate referrals will be returned ☐  |
| **Name of referring dentist** Click to enter text.**GDC number** Click to enter text. | **Date of referral** Click to enter a date. |
| **Address of referring dental practice** Click to enter text. |