Referral for oral / maxillofacial / specialist dentist review

Patients on or due to start medication associated with osteonecrosis of the jaw

Patient details

Name

Address

Email | Telephone

Date of birth | Hospital ID

NHS number | Date of review

Referring consultant | Referring department

Contact telephone number

Diagnosis

Planned oncological treatment

Reason for referral ☐ Pre-treatment ☐ During treatment

Urgency of referral ☐ Urgent ☐ Not urgent

Does patient have? ☐ Natural teeth ☐ No teeth ☐ Dentures

Dental problem ☐ Yes ☐ No

If yes ☐ Pain ☐ Swelling ☐ Abscess ☐ Loose tooth

☐ Other

Does patient have a dentist? ☐ Yes ☐ No If yes, when last seen

Planned start date/next administration of bisphosphonate/denosumab

Other medication

Other information

Name of clinician (print) | Date