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			Tele	phone	
Date of birth			Hos	pital ID	
NHS number			Date	e of review	
Referring consultant			Refe	rring department	
Contact telephone numb	er				
Diagnosis					
Planned oncological treat	tment				
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					

Date

Name of clinician (print)