# Adult Referral - please complete ALL the information

## Patient details

**Title:** Click or tap here to enter text.

**First name:** Click or tap here to enter text.

**Last name:** Click or tap here to enter text.

**NHS number:** Click or tap here to enter text.

**Date of birth:** Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**Telephone number:** Click or tap here to enter text.

**Preferred language:** Click or tap here to enter text.

**Interpreter required: YES** **[ ]  NO** **[ ]**

**Gender:**

**Accessibility issues:** Click or tap here to enter text.

**Cleft type:** Click or tap here to enter text.

## Reason for referral

**Please state why the patient wishes to be referred to the cleft team**

Click or tap here to enter text.

## Past medical history

**Past operations (please include cleft operations, location, and dates)**

Click or tap here to enter text.

**Please state cleft team the patient was previously under**

Click or tap here to enter text.

**Past medical diagnoses**

Click or tap here to enter text.

## Current medical history

**Current medication**

Click or tap here to enter text.

**Current medical diagnoses**

Click or tap here to enter text.

**Please provide GP/GDP information if you are not the referrer (please state if not registered)**

Click or tap here to enter text.

**Please state anything else you feel may be relevant to this referral.**

Click or tap here to enter text.

## Current dental history (to be completed if GDP referring)

Please note patients being referred for specialist dental or orthodontic care will need to be registered with and referred by a local dentist. Regular check-ups and care will still need to be undertaken by their dentist.

**Please tick to confirm that the patient’s periodontal disease and caries are stabilised: [ ]**

**Please provide BPE scores**

Click or tap here to enter text.

**Please include radiographs**

Click or tap here to enter text.

## Referral details

**Referrer name**

Click or tap here to enter text.

**Referrer designation**

Click or tap here to enter text.

**Referrer organisation**

Click or tap here to enter text.

**Referrer address**

Click or tap here to enter text.

**Referrer telephone number**

Click or tap here to enter text.

**Signed:**

**Date:** 01/01/2024

Please send your completed form to add-tr.cleftneteast@nhs.net and mark for the attention of the Cleft Coordinator or send via post to

Cleft Coordinator, CleftNetEast Cambridge University Hospitals Foundation Trust, Box 106, Hills Road, Cambridge, CB2 0QQ