RHIWBINA DENTAL

FACIAL PAIN REFERRAL FORM

Prior to referring the following criteria must be met:

- Dental causes for the pain must be excluded prior to referral.
- If a dental cause cannot be excluded the patient should be referred to an appropriate dental specialist for assessment.
- Facial pain associated with cardinal nasal (blockage, discharge) and / or ear (blockage, discharge, deafness, tinnitus, vertigo) symptoms should be referred for an ENT opinion and have any such causes excluded.

GP Name and Address .....

..... Postcode .....

REFERRING PRACTITIONER

Name .....

Address .....

..... Postcode .....

Tel ..... Fax .....

Email ..... Date .....

PATIENT DETAILS

Name .....

Address .....

..... Postcode .....

Date of Birth ..... Tel .....

Email .....

Has a dental cause for the pain been excluded? ☐

Has an ear nose and throat cause for the pain been excluded? ☐

Please return this completed referral form to: Rhiwbina Dental, Heol Y Forlan, Whitchurch, Cardiff CF14 1AX
T: 029 20626551 E: reception@rhiwbinadental.com www.rhiwbinadental.com

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Provisional diagnosis / What has the patient been told

Duration of pain overall (date of the first episode of this pain)

Please check the most appropriate:

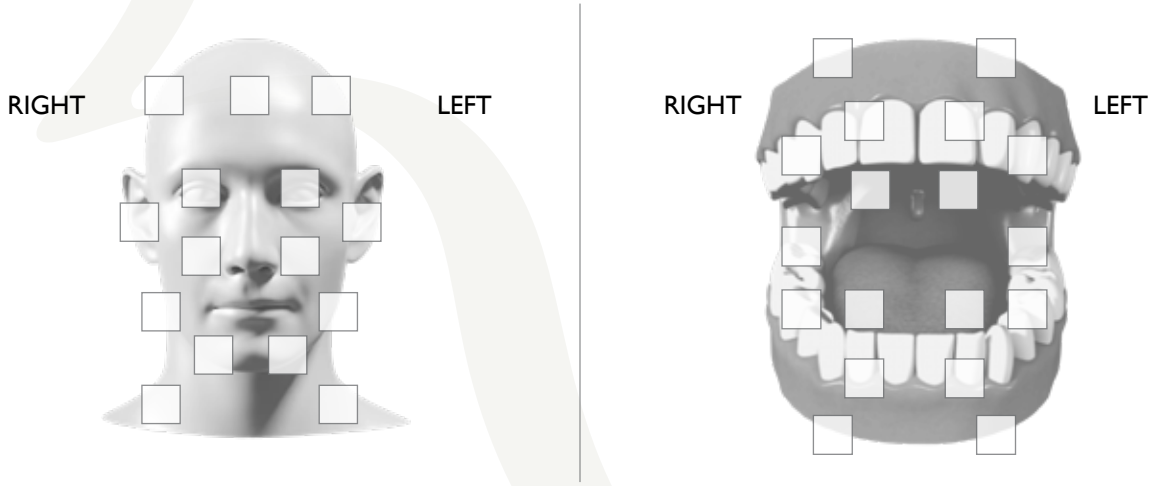
Pain is continuous with slight fluctuations in severity ☐

Pain is continuous with significant fluctuation of severity ☐

Pain attacks with episodes or no pain in between ☐

SITE OF PAIN AND ITS RADIATION

Please show on diagram



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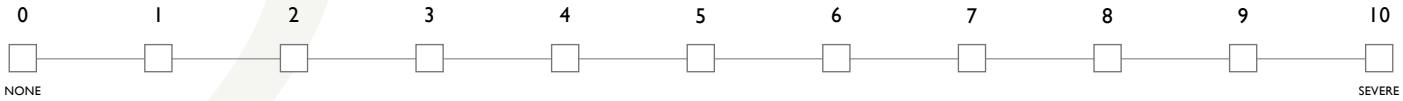
Further details on site of pain and its radiation

Any other sites of pain elsewhere on the body

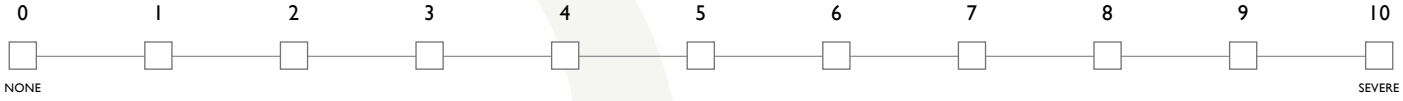
Character (how the patient describes how the pain feels)

Severity on a scale of 0 - 10 (10 being most severe, 0 being no pain)

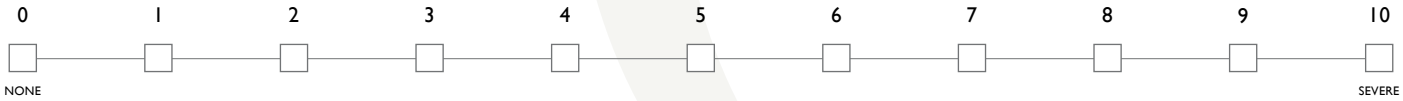
Current level of pain



Worst level of pain over last 4 weeks



Least level of pain over last 4 weeks



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FACIAL PAIN REFERRAL FORM

Provoking factors

Relieving factors

Any other associated factors

Current / Past treatments for pain

Medication	Current	Dose	Duration of use	Effective	Adverse effects
	Yes / No			Yes / No	
	Yes / No			Yes / No	
	Yes / No			Yes / No	
	Yes / No			Yes / No	
	Yes / No			Yes / No	

Other treatments (e.g. occlusal splints, dental restorations, endodontics, extraction, physiotherapy, osteopathy, alternative medicine, acupuncture, low intensity laser, TENS, homeopathy, chiropractor, hypnosis) Please specify:

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FACIAL PAIN REFERRAL FORM

Previous consultations for pain (e.g. GP, oral surgeon, neurologist, physician, psychiatrist, ENT surgeon, neurosurgeon, psychologist, pain specialist, counsellor, rheumatologist etc.) Please specify:

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Medical and psychological history – (If answer is yes, please provide details)

	YES	DETAILS
Previous operations / hospital admissions	☐	.....
Cardiac / hypertension	☐	.....
Respiratory	☐	.....
Dermatological	☐	.....
Diabetes / other endocrine	☐	.....
Gastrointestinal	☐	.....
Liver / Hepatitis	☐	.....
Renal	☐	.....
Musculoskeletal / other pains	☐	.....
Neurological / Migraines	☐	.....
Mental health	☐	.....
Allergy	☐	.....

Other (please give details)

.....

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.....

.....

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FACIAL PAIN REFERRAL FORM

Please list the patient's current medications

Medication	Additional Information

Relevant family / social history that could influence pain and the patients ability to manage pain

Any other relevant details

Name of referring clinician

Job title (e.g. Dentist / GP / Consultant)

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