NHS

Cumbria and the North East

ORTHODONTIC ASSESSMENT AND TREATMENT REFERRAL FORM

- ** indicates mandatory field*
- *Referral for advice accepted where clinically justified, not at patient/parent request.*
- *Please include as much information as possible (including any models, radiographs and photographs).*
- *Please note forms not correctly completed will be returned and not processed*

Patient Information - *Complete for ALL REFERRALS*					
Title*		**Sex***	Select	**Age***	
First Name*		**Surname***			
Full Address*		**Date of Birth***			
		NHS Number			
Postcode*		**Telephone (mobile)***			
Email address					
Social/Medical history information (including carer):					

Practice / referrer Information - *Complete for ALL REFERRALS*	
Referring GDP name*	
GDC number*	
Address*	
Postcode*	
Telephone number*	
NHS.net Email Address (where available)	
Date of decision to refer*	
Today's date*	
Referring GDP Signature*	

Pre-referral check list – *All criteria to be fulfilled unless stated**	
Under 18 years old on the date of referral (unless complex/multidisciplinary referral into secondary care)	
Patient motivated to undergo orthodontic treatment ***(unless assessment only referral)***	
As a general rule the NHS will only fund one course of Orthodontic treatment. Please confirm the patient has not had a previous course of Orthodontic treatment elsewhere on the NHS prior to referral	
Oral health stable and oral hygiene acceptable for orthodontic treatment ***(unless assessment only referral)***	
Patient and parents/carers been advised they may not be eligible for NHS treatment	
Patient in/close to permanent dentition. ***(If not please give reason for referral in 'Advice / Early referral' section)***	
Bitewing radiographs up to date/ treatment completed in accordance with 'Delivering Better Oral Health Toolkit'	
Responsibilities including attending regular appointments understood	
Copies of relevant / recent radiographs enclosed	

**Referral target – *enter name of desired provider in box ** **	
Primary care	
Secondary care	
Community Dental Service (where applicable)	

Reason for referral*	
Treatment	
Advice only / early treatment	

Referring for treatment? - *Complete this section ticking all that apply*		
Missing / impacted teeth	In any quadrant (excluding third molars or where no restorative need for space closure/alignment exists)	
Overjet	> 3.5mm but <=6mm with incompetent lips	
	Greater than 6mm	
	Reverse OJ >1mm	
Crossbites	Anterior or posterior with displacement > 2mm	
Displacement contact point / crowding	Moderate crowding (> 2mm contact point displacement)	
	Severe crowding (> 4mm contact point displacement)	
Overbite	Complete and potentially traumatic	
	Extreme open bites posterior or anterior	
Other clinical features	Severe Jaw Discrepancies	
	Cleft lip/palate or other craniofacial syndrome	
	Submerging primary teeth (below contact point)	
If referring for reason not listed please provide details:		

Referring for advice only/early treatment? - *Complete this section*	
Trauma risk (Increased overjet with lip trap/incompetent lips)	
Disturbed / abnormal eruption sequence	
Advice re interceptive extractions (e.g. first molars of poor prognosis)	
Anterior crossbite with displacement	
Posterior crossbite with displacement	
Impacted teeth including 'submerging' deciduous molars (or canines not palpable)	
Supernumerary teeth	
Other (**MUST** give details below)	
Further details:	

Referring into Secondary Care? – *Complete this section for all secondary care referrals*		
Advice only / early referral		
Treatment planning		
Treatment e.g.	Multidisciplinary treatment including: • *Severe jaw discrepancy* • *Cleft Lip and Palate / facial deformity* • *Multiple missing teeth* • *Tooth impactions +/- supernumerary teeth* • *Other complex malocclusions*	
Further details (must be given):		