

# Orthodontic Referral Form

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Referring dentist name & address:

NHS or Private referral (delete as applicable)

teeth present     
  missing teeth     
  impacted teeth

Overjet: Reverse and greater than -1mm

-1mm to 2mm       2-6mm

6-9mm       More than 9mm

Referral to:

Patient's name:

DOB:

Age:

Address:

Postcode:

Tel no:

Presenting problem	Please identify the main presenting problem only by ticking a column on the right. The clear spaces indicate the normal patient pathway to use for each problem. Using this form will help your patient to see the right person at the right time.	Refer to hospital	Refer to specialist	Keep under review	Referral not indicated
Increased overjet	Overjet 10+mm Age 10+yrs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Overjet 10+mm Age under 10yrs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Overjet 6-9mm Age 10+yrs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Overjet 6-9mm Age under 10yrs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Overjet under 5mm Any age	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Incisor crossbite	One or two incisor teeth in crossbite <i>At any age - early referral recommended</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Three or four incisor teeth in crossbite <i>At any age - early referral recommended</i>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Crowding	More than four deciduous molars still present	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Four or less deciduous molars present with:	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Mild crowding with little aesthetic detriment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
	Marked crowding or irregularity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Upper canines not palpable buccally	Age under 10yrs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
	Age 10+yrs – take parallax radiographs:	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Canines buccally placed or in line	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
	Canines palatally placed	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Class II division 2 malocclusions – late mixed dentition preferred	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Hypodontia – more than one tooth absent per quadrant (ignore 8's)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Hypodontia – not more than one tooth absent per quadrant (ignore 8's)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Cleft lip and palate, syndromes, medical history complicating treatment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Problems likely to need specialist surgical or restorative care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Problems not covered above – refer as most appropriate, add details below	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

OH good? Yes  No  (Please tick)

Radiographs sent in: OPG  Intraorals  (Please tick)

Other comments or complicating factors:

Dentist's signature

Date

