Dentist Referral Form for Orthodontics

the dental health centre

Referring Dentist Details

Referring Dentist's Name ..... GDC No. .....

Practice Address .....

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Practice Name ..... Practice Telephone .....

Practice E-mail ..... Practice Fax .....

Patient's Details

Patient's Name ..... Patient's DOB .....

Patient's Address .....

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Patient's Telephone ..... Patient's E-mail .....

Relevant Medical History (please include known allergies and current medication)

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Referral Type

☐ NHS (under 18)

☐ Private (all adult/child patients)

Reason for Referral

☐ Assessment and treatment

☐ Assessment only

☐ Early/mixed dentition assessment

Indication for early referral:

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Patient complaint:

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Dental History

Attendance:

☐ Regular ☐ Occasional ☐ First appointment

Motivation:

☐ Good ☐ Uncertain ☐ Poor

Oral hygiene:

☐ Good ☐ Fair ☐ Poor

Previous orthodontic treatment (please give details):

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Clinical Condition (tick all that apply)

☐ Crowding ☐ Increased overbite

☐ Missing teeth ☐ Reverse overjet

☐ Increased overjet ☐ Anterior open bite

☐ Impacted teeth

☐ Other reason (please specify):

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Relevant Radiographs Enclosed

☐ OPT ☐ Bitewings ☐ Periapical

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