

Patient Referral Form

PATIENT DEMOGRAPHIC DETAILS	DETAILS OF REFERRING PRACTITIONER
Title: First name: Surname: DOB: Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Address: Postcode Telephone: Mobile number: e-mail: Interpreter needed? <input type="checkbox"/> No <input type="checkbox"/> Yes Copy of referral given to patient? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name: Practice address: Practice postcode: Telephone: Fax/e-mail: GP PRACTICE GP name: Practice name & address:

DETAILS OF REFERRAL Speciality referred to: Is the referral: <input type="checkbox"/> Treatment <input type="checkbox"/> Advice/ Second opinion <input type="checkbox"/> Routine <input type="checkbox"/> Urgent - Why is this an urgent referral?

Details of the problem Please give an outline of the patient's condition, diagnosis and the clinical circumstances of the case /teeth involved.
--

Relevant medical history and drug history
--

Relevant dental history Please outline any previous treatment relevant to this issue, with details of the patient's response to treatment.

Radiographs: <input type="checkbox"/> No <input type="checkbox"/> Yes If there are no attached radiographs please explain why
--

Study Models: <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you want items returned to the practice? <input type="checkbox"/> No <input type="checkbox"/> Yes
--	--

Date:	Signature:
-------	------------

Orthodontic Referrals

Referral to NHS secondary care	
	Please tick
Severe skeletal anomalies and malocclusions likely to require interdisciplinary care such as orthognathic surgery, ankylosed teeth, impacted/ ectopic teeth	
Malocclusions requiring multidisciplinary care (advanced restorative care) such as hypodontia (more than 1 tooth missing in any quadrant), developmental anomalies affecting tooth structure, severe tooth surface loss	
Severely submerged deciduous teeth	
Patients with challenging physical or mental disabilities or complex medical history	
Cleft lip and/or palate or other craniofacial anomalies	
Patients over the age of 18 requiring complex multidisciplinary care	

Referral to NHS primary care	
	Please tick
Overjet of more than 6mm	
Reverse overjet with problems	
Traumatic overbite	
Open bites of more than 4mm	
Cross bite with displacement	
Missing teeth	
Supernumerary teeth	
Impacted teeth including canines	
Submerged deciduous teeth	
Severe crowding of teeth (contact point displacement of more than 4mm)	

Referral for other reasons	
	Please tick
Patients who are over 18 for private assessment	
Patients who are under 18 for private assessment	
Advice concerning teeth of poor prognosis	
Second opinion required	
Additional referral information e.g. reason for referral if the patient is under 10 years old/ explanation if patient has already been referred elsewhere/ previous failed treatment	

Responsibilities of referring dentist	
I certify that	Please tick
I have discussed the commitment required to undertake orthodontic treatment with the patient and the patient is highly motivated and is prepared to wear appliances	
The patient has good oral hygiene and no active disease	
I have provided preventive advice and treatment where necessary for the patient and will continue to do so through orthodontic treatment	
I will work with the orthodontist to enable treatment to be progressed including the extraction of teeth where necessary and preventive/ restorative work as required	
I have enclosed relevant radiographs and study models where appropriate	

Please note that referrals to this service will be monitored for audit purposes	
To be completed by the clinician accepting the referral	
This referral is appropriate for specialist primary/ secondary orthodontic care State reason:	Yes/ No