NHS
Nottingham City and Nottinghamshire County

ORTHODONTIC SERVICE REFERRAL FORM

Referring Dentist's Name & Address:	Patient's Name:_____ Name of parent/guardian:_____ D.O.B.:_____ Age:_____ Sex: M / F (Please circle) Address:_____ _____ Postcode:_____ Telephone: _____
Referral to:	**GOOD ORAL HEALTH: YES / NO** (Please circle) ***If no please justify reason for referral below or form may be returned.***

Presenting Problem	Indicate the ***main* presenting problem *only*** by ticking a column on the right hand side	Refer to Hospital service	Refer to Specialist Practice	Keep under review in practice	Referral not indicated at this time
Increased overjet	Overjet 9+ mm Age 10+ yrs				
	Overjet 6-9mm Age 10+ yrs				
	Overjet under 6mm Any Age				
Incisor crossbite	Anterior crossbite Age 7+ yrs				
Crowding	More than 4 deciduous molars still present				
	Marked crowding or irregularity				
	Mild crowding with significant aesthetic detriment				
	Mild crowding				
Upper canine(s)	Not palpable buccally Age under 10 yrs				
	Not palpable buccally Age over 10 yrs				
	Unerupted Age 12+ yrs & C/C's retained				
Class II division 2 malocclusion – late mixed dentition preferred					
Hypodontia	**Not more** than 1 tooth absent per quadrant (ignore 8's)				
	More than 1 tooth absent per quadrant (ignore 8's)				
Cleft lip and palate, Syndromes, medical history complicating treatment		*Please give details below*			
Problems likely to require specialist surgical or restorative care		*Please give details below*			
Malocclusion associated with skeletal discrepancies or facial asymmetry		*Please give details below*			
Problems not covered above: add details below or over page			*Please give details below*		

Have any radiographs been taken within the last 12 months: YES / NO (Please circle)

Radiographs sent in: **OPG**: YES / NO (Please circle) **Intra-orals** : YES / NO (Please circle)

Relevant medical and dental history, complicating factors e.g. molar prognosis, other comments, etc

I confirm that this patient has not been referred to another Orthodontic Specialist.

Dentist's Signature:_____ Date of referral: ____/____/_____