Orthodontic Referral Form

FP17ORN V1 08/08/2018

Patient Information - complete in CAPITALS

NHS Number

Surname

Forename

House number

Street

City or Town

County

Postcode

Email Address

Telephone No.

Title

Sex **M** or **F**

Date of Birth D D M M Y Y Y Y

Parent/Gaurdian Name

Relationship to Patient

Exemptions and Remissions

- [ ] Patient under 18
- [ ] Aged 18 in full-time education
- [ ] Other - Please enter details

Referral Details

Referring GDP Name

Referring GDP Practice Address

Street

City or Town

County

Postcode

Referring GDP Email Address and Telephone Number

Contract/Location Number

Performer Number

Clinical Information Relating to the Named Patient

Main Complaint

Reason for Referral

- ☐ Assessment and Treatment
- ☐ Advice Only
- ☐ Re-referral/Second Opinion — If yes please specify
  - Where
  - Reasons why second referral

Patient Motivation

- ☐ Patient only wants treatment
- ☐ Patient/carer wants treatment
- ☐ Patient/carer and Patient wants treatment
- ☐ GDP wants advice only

Oral Hygiene

- ☐ Good
- ☐ Some Improvement required - Please detail steps in place to manage below
- ☐ Poor, advice only

Caries Present

- ☐ Yes - Please specify which teeth and if restoration planned or opinion on extractions
- ☐ No

IOTN Dental Health Component | **IOTN DHC qualifier** | **IOTN Aesthetic Component**

Relevant Medical History (include medications and known allergies)

Radiographs ☐ **Digital Study models** ☐

Referral Type

- Primary Care ☐ Preferred Provider
- Secondary Care ☐ Preferred Provider