Orthodontic Case Assessment

Contract Number

Date

Performer responsible for the treatment plan:

Name

Performer Number

Performer responsible for completing the course of treatment:

Name

Performer Number

Any other clinicians (Performers or therapists) involved in the course of treatment:

Clinician's name	Performer number	GDC number	Number of visits

Patient's details

PLEASE COMPETE IN BLOCK CAPITALS

First name

Age of patient at start of treatment

Surname

Pre-treatment IOTN score: DHC grade (1 to 5) ☐ DHC qualifier (a to x) ☐ AC grade (1 to 10) ☐

Part 1 - Assessment

Extra-oral (Please tick the appropriate boxes)

Skeletal classification Class I ☐ Class II ☐ Class III ☐

FM angle High ☐ Average ☐ Low ☐

Transverse asymmetry? Yes ☐ No ☐ Lips-competent? Yes ☐ No ☐

Intra-oral: (Please tick the appropriate boxes)

Teeth present

Oral hygiene Good ☐ Average ☐ Poor ☐ Erosion/decalcification evident? Yes ☐ No ☐

Caries evident

Teeth of doubtful prognosis

Occlusion: (Please tick the appropriate boxes)

Incisor relationship Class I ☐ Class II/1 ☐ Class II/2 ☐ Class III ☐

Overjet ☐ mm Edge-to-edge ☐ Reverse ☐ mm

Overbite Increased ☐ Average ☐ Decreased ☐ Complete ☐ Incomplete ☐ Anterior open-bite ☐ mm

Centre lines (show shift by arrows)

Anterior cross-bites

Buccal occlusion Right: Class I ☐ Class II 1/4 unit ☐ 1/2 unit ☐ 3/4 unit ☐ full unit ☐ Class III ☐

Left: Class I ☐ Class II 1/4 unit ☐ 1/2 unit ☐ 3/4 unit ☐ full unit ☐ Class III ☐

Posterior cross-bites

Associated mandibular displacement (mm) Right ☐ Left ☐ Anterior ☐

Radiographs:

Number obtained Panoramic ☐ Lateral cephalometric ☐ Intra-oral ☐

Teeth absent Pathology evident Yes ☐ No ☐

Details

Cephalometric analysis SNA ☐° SNB ☐° MMPA ☐° UI-MxP ☐° LI-MdP ☐° LI-APo ☐ mm

Part 2 - Treatment

Was an FP17 DCO given to the patient? Yes ☐ No ☐

Aims of Treatment: (Please tick the appropriate boxes)

Relief of crowding ☐ Maxillary arch-expansion ☐ Alignment ☐ Levelling ☐ Arch co-ordination ☐ Space closure ☐

Correction of incisor relationship ☐ Correction of buccal segment occlusion: antero-posteriorly ☐ laterally ☐

Extractions: ——————

Appliances Provided:

Type of appliance		Date fitted	Date withdrawn / removed
Removable appliance	Upper:		
	Lower:		
Functional appliance			
Upper fixed appliance			
Lower fixed appliance			
Removable retainers	Upper:		
	Lower:		
Fixed retainers	Upper:		
	Lower:		

Retention regime (months): (Please tick the appropriate boxes)

Full-time ☐ Part-time ☐ Nocturnal ☐

Duration of supervised retention ☐

Has the course of treatment been successfully completed? Yes ☐ No ☐

If 'No' was treatment: abandoned ☐ discontinued ☐ or still on-going ☐

Are you satisfied with the result? Yes ☐ No ☐ N/A ☐

If 'No' why not?

Are there any missing records? (Please specify)

Any other relevant information you wish to be taken into consideration? (e.g. treatment of intentionally limited objectives or poor patient co-operation).