ORTHODONTIC REFERRAL FORM V1

Please complete and send to only ONE of the below (multiple referrals will be rejected by all providers):

{my}Orthodontist
2 The Crescent, Plymouth PL1 3AB *Tel: 01752 222 444*

Plymouth Orthodontics
60 Lower Compton Road, Plymouth PL3 5DW *Tel: 01752 662 554*

University Hospitals Plymouth NHS Trust
Orthodontic Department, Derriford Hospital, Plymouth PL6 8DH *Tel: 01752 432 983*

PATIENT DETAILS	
FULL PATIENT DETAILS	**GDP (REFERRER) DETAILS**
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐ Male ☐ Female ☐ **NHS Number:** Surname: First name: Date of Birth: Address: Town/City: Postcode: Telephone Number: Mobile Number: E-mail Address:	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Other ☐ Surname: First name: Job Title: GDC Number: Practice Name: Practice Address: Town/City: Postcode: Telephone Number: E-mail Address:
MEDICAL HISTORY/SOCIAL DETAILS	
MEDICAL HISTORY **YES** ☐ **NONE** ☐ Please detail:	**MEDICATION LIST** **YES** ☐ **NONE** ☐ Please detail:
ALCOHOL INTAKE **YES** ☐ **NONE** ☐ Please detail:	**SMOKER/VAPOUR/EX SMOKER** **YES** ☐ **NO** ☐ Please detail:
ALLERGIES **YES** ☐ **NONE** ☐ Please state allergy and description of reaction, if known.	**OTHER INFORMATION** (E.g. Living arrangements, Legal guardian)
PATIENT GMP DETAILS *(if not the referrer)*	**COMMUNICATION & SPECIAL REQUIREMENTS**
Practice Name: Practice Address: Town/City: Postcode: Telephone Number: E-mail Address:	Does the patient communicate in a language or mode other than English? YES ☐, please detail. NO ☐ Is an interpreter required? YES ☐, please detail. NO ☐ Does the patient have any special requirements? YES ☐, please detail. NO ☐
REFERRAL INFORMATION	
Date of referral: …… **URGENT*** ☐ **ROUTINE** ☐ *please justify in the information box on next page	Type of referral *(please tick)* **A) New Referral** ☐ **B) Second Opinion** ☐ **C) Transfer case** ☐
Has the patient had previous orthodontic treatment? **YES** ☐ **NO** ☐	

REASON FOR REFERRAL *Please circle the correct reason for referral. Please note the **yellow** boxes indicate that a hospital referral is required.*				
IOTN SCORE		**5**	**4**	**3**
NEED FOR TREATMENT		**Very Great**	**Great**	**Moderate**
a	**Overjet**	>9mm	6.1-9mm	3.5-6mm Incompetent lips
b	**Reverse overjet**		>-3.5mm	-1 to - 3.5mm
c	**Crossbite**		>2mm	1-2mm
d	**Tooth displacement**		>4mm	2-4mm
e	**Openbite**		>4mm	2-4mm
f	**Overbite**		Increased complete & trauma	Increased/ complete & no trauma
h	**Hypodontia Missing teeth**	>1 tooth per quadrant	Less than 1 tooth per quadrant	
i	**Impeded eruption**	Due to crowding, displacement, pathology		
l	**Posterior/ Lingual crossbite**		No functional occlusion	
m	**Reverse overjet**	>3.5 with speech or masticatory problems	>1-3.5 with speech or masticatory problems	
p	**Cleft & Craniofacial**	Yes		
s	**Primary teeth**	Infra occluded		
t	**Partially erupted**		Tipped or impacted	
x	**Supernumerary**		Supernumerary	

HOSPITAL OR MDT REFERRALS				
Patient with medical developmental or social problems needing Hospital care.	Patient needing orthognathic MDT (e.g. significant skeletal discrepancies)	Patient needing ortho and oral surgery MDT (i.e. multiple impacted teeth)	Patient with complex problems needing ortho and rest dent MDT	Patient with complex medical issues, including psychological concerns.

INFORMATION TO SUPPORT REFERRAL
(Please attach additional sheets if necessary)

SUITABILITY OF PATIENT FOR REFERRAL

Patients should only be referred after the following has been achieved.

Please tick to confirm:

- ☐ Oral Hygiene Instruction and diet advice have been given (OH needs to be excellent prior to treatment starting)
- ☐ Patient is caries free and/or caries have been stabilised
- ☐ High quality print/DICOM file(s) of relevant radiographs have been included/emailed to provider

Print Name		GDC No		Signature		Date	