

ORTHODONTIC ASSESSMENT AND TREATMENT REFERRAL FORM PART 1 – PATIENT DETAILS

*\* indicates mandatory field. Please note forms not correctly completed will be returned and not processed Referral for advice accepted where clinically justified, not at patient/parent request.  
Please include as much information as possible (including any models, radiographs and photographs).*

Section 1. Practice / referrer Information - Complete for ALL REFERRALS			
Today's date*		Date of decision to refer*	
Referring GDP name*		GDC number	
Referring GDP Signature*		NHS.net address (where available)	
Practice Referrer Address*			
Postcode*		Telephone number*	

Section 2. Patient Information - Complete for ALL REFERRALS				
Title*		First Name*		Surname*
Date of Birth*		Age*		Gender*
Patient Address,				
Postcode*		Telephone (mobile)*		
NHS number		Patient e-mail address		
Social/Medical history information (including carer):		Current dental/oral health and relevant dental history		
Prevention has been provided in accordance with 'Delivering Better Oral Health Toolkit'				<input type="checkbox"/>
Bitewing radiographs taken as appropriate & treatment planned/completed				<input type="checkbox"/>

Section 3: Pre-referral checklist – Complete for ALL REFERRALS (all domains must be ticked unless as outlined below)	
Patient is under 18 years old on the date of referral *	<input type="checkbox"/>
Relevant are radiographs enclosed (e.g. DPT)	<input type="checkbox"/>
Patient has stable Oral Health and Oral Hygiene suitable for Orthodontic Treatment#	<input type="checkbox"/>
Patient is in or close to the Permanent Dentition #	<input type="checkbox"/>
Patient has not had a previous course of comprehensive NHS Orthodontic Treatment	<input type="checkbox"/>
<b>* Patients over the age of 18 can be referred to Secondary care for an opinion on multidisciplinary management</b>	
<b># If unable to tick this box, consider if suitable for referral for advice/early management only, or if more appropriate to delay referral until dental health assured or further dental development has occurred</b>	

Section 4. Referring for advice only/early treatment? - Complete this section	
Trauma risk (Increased overjet with lip trap/incompetent lips)	<input type="checkbox"/>
Disturbed / abnormal eruption sequence / Supernumerary teeth	<input type="checkbox"/>
Advice regarding interceptive extractions (e.g. first molars of poor prognosis)	<input type="checkbox"/>
Anterior or posterior crossbite with displacement	<input type="checkbox"/>
Impacted teeth including 'submerging' deciduous molars (or permanent canines not palpable at age 10)	<input type="checkbox"/>
Other ( <b>MUST</b> give details here):	

Section 5. Referring for comprehensive orthodontic treatment? - Complete this section	
Patient is motivated to undergo Orthodontic Treatment	<input type="checkbox"/>
Patient/Parent understand responsibilities including attending regular appointments	<input type="checkbox"/>
Patient/Parent understand final eligibility will be determined by the Orthodontist	<input type="checkbox"/>
Patients main concern/orthodontic concern: :	

Section 6: IOTN – Complete for ALL REFERRALS (note: below is not a complete list)			
IOTN Dental Health Component (DHC)	IOTN 5	IOTN 4	IOTN 3*
Unerupted and Impacted/Ectopic Teeth	<input type="checkbox"/>		
Hypodontia, in any one quadrant (not 8's)	> 1 tooth missing <input type="checkbox"/>	Only 1 tooth missing <input type="checkbox"/>	
Overjet	> 9mm <input type="checkbox"/>	> 6mm but <=9mm <input type="checkbox"/>	> 3.5mm but <=6mm With Incompetent Lips <input type="checkbox"/>
Reverse overjet (-)	> 3.5mm <input type="checkbox"/>	> 1mm but <3.5mm Masticatory/Speech problems <input type="checkbox"/>	> 1mm but <3.5mm No Masticatory/Speech problems <input type="checkbox"/>
Anterior or posterior buccal Crossbites		> 2mm slide From RCP to ICP <input type="checkbox"/>	> 1mm but <2mm slide From RCP to ICP <input type="checkbox"/>
Lingual crossbite		No occlusal contact in 1 or both buccal segments <input type="checkbox"/>	
Contact point displacements between teeth		> 4mm <input type="checkbox"/>	> 2mm but <4mm <input type="checkbox"/>
Anterior open bite (AOB)		AOB > 4mm <input type="checkbox"/>	AOB > 2mm but <4mm <input type="checkbox"/>
Increased and complete Overbite		with gingival /palatal trauma <input type="checkbox"/>	without gingival /palatal trauma <input type="checkbox"/>
<b>Alternatively, please provide IOTN (DHC) Score:</b>			
<b>* Include Aesthetic Component if IOTN category 3 or below (full guide in BOS Easy IOTN App) :</b>			
<b>Please note IOTN below 3, or 3 with an aesthetic component of &lt;6 would not meet the eligibility threshold for NHS Orthodontic Treatment</b>			

Section 7. Referring into Secondary Care? – Also complete this section for all secondary care referrals			
Advice only / early referral			<input type="checkbox"/>
Treatment planning, (for providers with an NHS orthodontic contract)			<input type="checkbox"/>
Complex malocclusions /Multidisciplinary orthodontic treatment.	Unerupted and Impacted/Ectopic Teeth	<input type="checkbox"/>	Severe jaw discrepancy/Facial Deformity <input type="checkbox"/>
	Hypodontia	<input type="checkbox"/>	Cleft Lip and Palate <input type="checkbox"/>
Other/ Further details:			

Section 8 - Referral target – Please read Section 9, prior to making your decision (please note: incomplete or inappropriate referrals will be rejected)		
Specialist Practice (Primary care)	<input type="checkbox"/>	Enter name of desired provider here:
Community Dental Service (Primary care) -where available	<input type="checkbox"/>	
Hospital services (Secondary care)	<input type="checkbox"/>	

<b>Section 9 : Referral target guidance – Please read before making a referral:</b>	
<b>Specialist Practice (Primary care)</b>	Patients who are under 18 and in or close to the permanent dentition, who qualify for NHS Orthodontic Treatment (e.g. Any IOTN DHC 4. A small proportion of IOTN DHC 3 qualify when the Aesthetic Component is 6 or greater). Interceptive advice and treatment can also be offered.
<b>Community Dental Service (Primary care)</b>	Patients meeting the criteria for Primary Care above, but additional priority for patients with problems accessing care due to social, medical or geographic reasons. Please check with your local provider prior to referral.
<b>Hospital service (Secondary care):</b>	No specific age restrictions. Referrals are accepted for interceptive advice and treatment, and multidisciplinary treatment (e.g. Impacted teeth, hypodontia, skeletally based malocclusions, orthognathic surgery). IOTN 5's are most likely to be considered appropriate for referral to secondary care. Other IOTNs may be accepted if multidisciplinary care is required, or for teaching purposes.