St George's University Hospitals NHS
NHS Foundation Trust

Referral for NHS Orthodontic Treatment

Please note that you must complete **all** sections of this form. If any section is incomplete, your referral may not be accepted.

SECTION 1 – PATIENT DETAILS

Name: _____ Date of Birth: _____

Address: _____ Gender: ☐ Male

_____ ☐ Female

_____ Tel: _____

Postcode: _____

SECTION 2 – REFERRER DETAILS

Name: _____ Practice Stamp (Address/Tel)

Signature: _____

Date: _____

SECTION 3 – REASON FOR REFERRAL

Presenting malocclusion: _____

The patient has the following: (Please tick all that apply)

☐ Hypodontia
☐ Likely surgical case
☐ Impacted teeth
☐ Traumatic overbite
☐ Malaligned contact area 4mm+
☐ Reverse OJ 1mm+
☐ Anterior open bite 4mm+
☐ Crossbite with 2mm+ displacement
☐ Overjet > 6mm

Please provide any additional information you feel we should know below:

E.g. Doubtful prognosis of 6's _____

_____

_____

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SECTION 4 – ADDITIONAL INFORMATION

Patient's medical history: _____

☐ I confirm that the oral hygiene is satisfactory and the oral health is stabilised.

SECTION 5 – ENCLOSURES

☐ I enclose an OPG taken on _____

☐ No OPG has been taken.

Once completed, please return this form to either Stgh-tr.referrals@nhs.net or Central Booking Service, St George's University Hospitals NHS Foundation Trust, Blackshaw Road, Tooting, London, SW17 0QT.