LONDON ORTHODONTIC REFERRAL FORM

Name of Referrer:	**Job title:**	
Organisation: **Address:** **Postcode:**	**Phone:** **Secure Email:** **Date of Referral:**	
Patient Surname:	**First Name(s):**	**Gender:** ☐Male ☐Female ☐Prefer not to say
Date of Birth:	**NHS Number:**	
Home Address: **Post Code:** **Phone:** **Email (Patient/Parent):**	**General Dentist Name:** (If different from referrer) **Address:** **Post Code:** **Phone:**	**General Medical Practitioner:** **Address:** **Post Code:** **Phone:**
Is this a Child Looked After ? (A Child Looked After is a child in the care of a Local Authority) ☐ Yes ☐ No	**Are there any safeguarding concerns for this patient?** ☐ Yes ☐ No If yes, give details here:	**Interpreter Required?** ☐ Yes ☐ No Language:

☐ **Special Educational Needs:** (please give details, e.g. autism, ADHD)

Medical History and Medication:

Is patient under hospital care for a medical reason?
☐ **Yes** ☐ **No**
If yes, which hospital:

Reason for Referral:
☐Opinion ☐Treatment if appropriate ☐In active treatment ☐Orthognathic ☐Poor prognosis 6s

Summary of Problem: (Please provide details sufficient to enable the provider to understand your request, and upload supporting information such as radiographs/photos or correspondence from other services.)

Priority:
☐Routine ☐Urgent If Urgent, provide reason here:

Images enclosed:
☐OPG ☐Lat Ceph ☐Periapical ☐Occlusal ☐Bitewings ☐CBCT ☐Photos ☐Other:

Supporting Information: (Please see supplementary guidance)

Is the patient motivated to undergo orthodontic treatment (wear an appliance)?	☐ **Yes**	☐ **No**
Is the patient dentally fit at the time of referral?	☐ **Yes**	☐ **No**
Is oral hygiene "good" to "excellent"?	☐ **Yes**	☐ **No**
Has the patient/parent been advised that they may not be eligible for NHS treatment?	☐ **Yes**	☐ **No**
Has the patient been referred for/received orthodontic treatment on the NHS before? If **yes**, give details here:	☐ **Yes**	☐ **No**

How does the patient meet the IOTN Referral criteria?
(Please select the **main** presenting problems)

Missing teeth	Hypodontia	☐ More than one tooth absent per quadrant (not 8s) (PA/OPG required)	
		☐ ONLY one tooth absent per quadrant (not 8s) (PA/OPG required)	
	Impacted tooth	☐ Unerupted maxillary central incisor (PA required)	
		☐ Impacted canine	
		☐ Impeded eruption of any other tooth	
Overjet	Increased	☐ Overjet >9mm	
		☐ Overjet >6mm	
		☐ Overjet >3.5mm with incompetent lips	
	Reverse	☐ Reverse overjet >3.5mm with/without masticatory difficulties	
		☐ Reverse overjet >1mm with masticatory and speech difficulties	
		☐ Reverse overjet >1mm WITHOUT masticatory and speech difficulties	
Crossbite	Anterior/ Posterior	☐ with >2mm discrepancy between RCP and ICP	
		☐ with >1mm discrepancy between RCP and ICP	
		☐ Posterior lingual crossbite with no functional occlusal contact on one or both sides	
Displacement of contact points	Crowding	☐ Contact point displacement >4mm	
		☐ Contact point displacement >2mm	
Open and overbites	Open bite	☐ Lateral or anterior open bite >4mm	
		☐ Lateral or anterior open bite >2mm	
	Overbite	☐ Increased with gingival or palatal trauma	
		☐ Increased with gingival or palatal contact but NO trauma	
Additional features		☐ Defects of cleft lip and palate and other craniofacial anomalies	
		☐ Submerged deciduous teeth	
		☐ Supernumerary teeth	
		☐ Partially erupted teeth, tipped and impacted against adjacent teeth	

Declaration:

☐ I have discussed the details of this referral with the patient and/or parent/carer.

☐ I agree to provide the patient and/or parent/carer with a copy of this referral.

THIS REFERRAL WILL NOT BE ACCEPTED WITHOUT COMPLETION OF ALL SECTIONS