Melton Orthodontics

Orthodontic Referral Form for Private Treatment

Date	Name of refering Dentist: Address: Tel: Email: (Or practice stamp of referring Dentist, make sure name of referring Dentist is Clear)
Address of Orthodontic Practice Melton Orthodontics 1st Floor, 3 Nottingham Street Melton Mowbray Leicestershire, LE13 1NN	

Patient Details IN BLOCK CAPITAL LETTERS please

Name		SEX M / F
Date of Birth	Age	NHS Number:
Address: POSTCODE:		
Telephone No:(Landline)	Mobile:	Email:
GP Name:		Practice:
GDP if different from above (name and address):		
Relevant medical history (any disability)		

This section must be completed. Please tick one or more appropriate features

Overjet	6.1mm - 9mm		*Greater than 9mm*		Reverse overjet greater than 1mm		
Overbite	Deep or potentially traumatic		*Extreme open bites lateral or anterior (greater than 4mm)*				
Crowding / Spacing	Moderate crowding (2mm or more contact point displacement)		Severe spacing (4mm or more contact point displacement)		Severe crowding (4mm or more contact point displacement)		
Hypodontia	Up to one tooth missing in any quadrant		*MORE THAN ONE TOOTH MISSING IN ANY QUADRANT*				
Other Clinical Features	*Ectopic/impacted teeth requiring surgery*		Crossbites anterior or posterior with displacement greater than 4mm		*SEVERE JAW DISCREPANCIES*		*CLEFT LIP/PALATE OR OTHER CRANIOFACIAL CONCERN*

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Please indicate:

Any permanent teeth absent? (Which are they?)

Any teeth of poor prognosis? (What is the plan for these?)

Are upper canines erupted – YES/NO

PLEASE CONFIRM:

Yes No

☐☐ Is the patient motivated to undergo orthodontic treatment (wear appliance)?
☐☐ Oral hygiene is good to excellent
☐☐ Is the patient dentally fit at the time of referral?

Please do not refer for orthodontic treatment if you cannot tick 'Yes' against all of the above. You can still refer for advice (e.g. extraction of decayed first permanent molars).

Have any radiographs been taken within the last 12 months: YES / NO (Please circle)
Please send all recent radiographsxrays sent : none / OPT/ PA / USO / BW's (please circle)

☐I confirm that this patient has not been referred to another Orthodontic Specialist.

Dentist signature: _____ Date: _____

Dentist GDC No:

Referrals will be sent back to the referring practitioner if all the relevant information on this form is not completed

Notes for Dentists:
Orthodontic treatment is time consuming, sometimes uncomfortable and requires commitment from the patient.
Patients with poor oral hygiene should not be referred until they can demonstrate appropriate levels of plaque control.
It is important that you discuss the nature of orthodontic treatment with your patient before referring them.
They should be aware that:

- It is important that all appointments are kept;
- Appliances must be worn as indicated;
- Treatment may take between 18 and 30 months and that a period of retention will be required(which may be permanent);
- Dietary advice and oral hygiene instructions must be adhered to;
- They require a genuine interest in undertaking orthodontic treatment with fixed appliances;
- They must achieve and maintain an excellent standard of oral hygiene and be dentally fit, and
- It is important that patients continue to visit their dentist for routine dental care.