Date Rec'd (for internal use):

Universal Orthodontic Referral Form

Only referrals made on this form will be accepted for NHS orthodontic treatment in North, East & South East Wales

PLEASE PRINT CLEARLY USING BLACK INK

Referral to:	**Referring Practitioner:**
Name: Address:	Name: Practice Stamp:
	GDP Details (if different):

Patient Details:

Name:

Address (including postcode):

Date of Birth: / /

Age:

Contact Telephone Numbers:

REFERRALS WILL BE SENT BACK TO THE REFERRING PRACTITIONER IF ALL THE RELEVANT INFORMATION ON THIS FORM IS NOT COMPLETED.

		Yes	No
a	Is the patient motivated to undergo orthodontic treatment (wear appliance)?		
b	Is the patient dentally fit at the time of referral?		
c	Is oral hygiene 'good' to 'excellent'?		
d	Have the patient and parents been advised that they may not be eligible for NHS treatment?		
e	Has the patient been referred for or received orthodontic treatment on the NHS previously?		

Reason for referral: Opinion ☐ Treatment ☐ Transfer ☐ Treatment Plan ☐

Radiographs Included: OPG ☐ Lat Ceph ☐ Periapical ☐ Occlusal ☐

Priority Referral	**Please Tick**
Decision on the management of recently (within 1-2 weeks) traumatised teeth	
Unerupted maxillary central incisor at age 7-8 years old **(IOPA Radiograph required)**	
Impacted permanent canines that are placing the incisor roots at risk **(Radiograph required)**	
Significant Class II skeletal discrepancies in patients approaching the pubertal growth spurt	
Patient below the age of 11 that have hypodontia, crowding or an increased overjet and require a GA for the extraction of an acutely symptomatic first permanent molar	
Significant medical or social history **(please provide details below)**	
Other reason (please give details)	

Please ensure all relevant radiographs are included

Presenting Problem	Please identify the ***main*** presenting problem only by ticking a column on the right. The clear spaces indicate the normal patient pathway to use for each problem. **NB** *Some cases suitable for specialist practice may also be accepted by hospital-based orthodontic units due their role as teaching institutions. Referrers are advised to liaise with their orthodontic providers if in doubt.*	Refer to hospital service	Refer to specialist practice	Keep under review at practice	Referral probably not indicated
Increased overjet	Overjet greater than 9mm *Age 10+yrs*				
	Overjet greater than 9mm *Age under 10yrs*				
	Overjet 6-9mm *Age 11+yrs*				
	Overjet 6-9mm *Age under 11yrs*				
	Overjet under 6mm *Any age*				
Incisor crossbite Early referral recommended	One or two incisor teeth in crossbite				
	Three or four incisor teeth in crossbite				
Crowding	*More than four deciduous molars still present*				
	Four or less deciduous molars present with:				
	- Marked crowding or irregularity				
	- Mild crowding, marked aesthetic detriment				
	- Mild crowding, little aesthetic detriment				
Upper canines not palpable buccally	*Age under 10yrs*				
	Age 10+yrs – take parallax radiographs				
	- Canines buccally placed or in line of the arch with sufficient space for eruption				
	- Canines buccally placed or in line of the arch with <4mm of space available for the canine				
	- Canines palatally placed				
Adults with severe malocclusions requiring multidisciplinary care					
Cleft lip and palate, syndromes, medical history complicating treatment					
Class II division 2 malocclusions – *late mixed dentition preferred*					
Hypodontia – more than one tooth absent per quadrant (ignore 8's)					
Hypodontia – *not* more than one tooth absent per quadrant (ignore 8's)					
Problems likely to need specialist surgical or restorative care					
Problems not covered above – *refer as most appropriate, add details below:*					

Other comments or complicating factors:

Referring Dental Practitioner's Signature:	**Date:**
Name:	**Performer Number:**

Please ensure all relevant radiographs are included