**Please complete all sections of this form. Incomplete forms will be returned.**

Please complete this form for any patient aged over 8 years of age and in need of NHS orthodontic treatment that meets the following criteria. He/She:

1. meets the requirements of the Index of Treatment Need (IOTN) 5, 4 or 3 with an aesthetic component of 6 or above.

2. is under the age of 18 for routine treatment in Primary Care.

Please include a copy of any relevant radiographs.

**SECTION ONE – PATIENT DETAILS**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GDP Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GMP Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION TWO – DETAILS OF REFERRER**

Name of Referrer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Address and Contact Tel

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As the referring practitioner, I confirm that

□The patient is aware of waiting times for their preferred providers.

□I am confident that the patient meets the referral conditions and has an understanding of the commitment required to undertake a course of orthodontic treatment.

**Please complete all sections of this form. Incomplete forms will be returned.**

**SECTION THREE – REFERRAL HISTORY**

Has this patient been referred before to other Orthodontic NHS Providers? Yes □ No □

**If Yes**, please specify where and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION FOUR – REASON FOR REFERRAL**

Please provide any additional information to support the referral.

**IOTN Category:** 3.6 or above □ 4 □ 5 □

**Oral Hygiene:**  Poor □ Good □

**Previous caries experience:**

**Patient motivation:** Poor □ Good □

**Radiograph included:** OPG □ Periapical □ Other □

Digital OPG □ Digital Periapical □ Other digital □

Standard Referral □ Urgent Referral □ Second Opinion □ (Please see Section Three)

Transfer of care □ Dispute □

Children Protection Issues □

**Further Comments/Details (must be completed):**

**For Office Use**

Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Enclosures Received □ Routine / Urgent / Reject

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For reference only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IOTN Score** | **5** | **4** | **3** | **2** |
| **Need for treatment** | **Very Great** | **Great** | **Borderline** | **Little** |
| a | Overjet | >9mm | 6-9mm | 3.5-6mm incompetent | 3.5-6mm competent |
| b | Reverse overjet |  | >3.5mm with NO speech or masticatory problems | 1-3.5mm | <1mm |
| c | Crossbite |  | >2mm | 1-2mm | <1mm |
| d | Tooth displacement |  | >4mm | 2-4mm | 1-2mm |
| e | Openbite |  | >4mm | 2-4mm | 1-2mm |
| f | Overbite |  | Increased, complete & traumatic | Increased, complete & no trauma | <3.5mm incomplete, no trauma |
| g | Pre or post normal occlusion |  |  |  | ½ unit discrepancy |
| h | Hypodontia | >1 tooth per quadrant | 1 tooth per quadrant |  |  |
| i | Impeded eruption | Crowding, displacement, pathology |  |  |  |
| l | Posterior, lingual crossbite |  | No functional occlusion |  |  |
| m | Reverse overjet | >3.5mm with speech and masticatory problems | 1-3.5mm with speech and masticatory problems |  |  |
| p | Cleft lip and palate | Yes |  |  |  |
| s | Deciduous teeth | Submerged |  |  |  |
| t | Partially erupted |  | Impacted |  |  |
| x | Supplemental |  | Supplemental |  |  |
| IOTN N/A | Teeth with Caries or Trauma with doubtful prognosis, monitoring growth, orthognathic surgery |

Patients in blue zones including patients with a Cleft Lip and Palate– refer to Hospital Service

Patients in green zones – refer to either Hospital Service (Consultant, Training Grades and DwSI) or Specialist Practice or DwSI for assessment

Patients in orange zones where aesthetic component is 6 or above – refer to Specialist Practice or

DwSI for assessment

Patients in red zones are not eligible for NHS treatment