Appendix 4

SPECIALIST ORTHODONTIC REFERRAL FORM

N.B

- **Complete EVERY section of this form and retain a copy for your records.**
- **Incomplete referrals will be returned.**
- **Attach this form to the completed Dental Referral Form.**
- **Securely attach any x-rays in a separate envelope to this form**
- **Please ensure that any study models are packed securely to prevent damage in transit**

Patient's name:		**Date of birth:**	
REASON FOR REFERRAL			
Patient's attendance record (tick):	☐ Regular	☐ Irregular	
BPE Score (tick highest score in any sextant)	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ higher		
Last caries incidence within (tick)	☐ Last 6 months	☐ Last 1 year	☐ More than 1 yr
Caries free now? (tick)	☐ Yes	☐ No	
Skeletal classification (tick)	☐ 1	☐ 2	☐ 3
Permanent canines erupted? (tick)	☐ Yes ☐ Lt ☐ Rt	☐ No ☐ Lt ☐ Rt	
If "no", is it palpable?	☐ Yes, Buccal	☐ Yes, Palatal	☐ No
Overjet (tick one)	☐ <0 – 5 mm	☐ 6 – 9 mm	☐ > 10 mm
Index of Orthodontic Treatment Need	**DHC (1 to 5) =**	**AC (1 to 10) =**	

Teeth developmentally missing/previously extracted? ☐ Yes ☐ No **If "Yes" please give details**
Supernumerary/extra teeth? ☐ Yes ☐ No **If "Yes" please give details**
Teeth with poor prognosis? ☐ Yes ☐ No **If "Yes" please give details**
Radiographs attached? ☐ Yes ☐ No **If "Yes" please give details** ☐ Bitewings ☐ Periapicals ☐ OPT ☐ Lateral Skull ☐ Other
Additional comments e.g. history of trauma (please use additional sheet if required and attach to this form)

Signature of referring practitioner: **Date:**