GIG CYMRU NHS WALES
South East Wales Orthodontic Managed Clinical Network

Date Rec'd (for internal use):

Orthodontic Referral Form

Only referrals made on this form will be accepted for NHS orthodontic treatment in South East Wales, except referrals to the University Dental Hospital, Cardiff for which there is a separate form.

PLEASE PRINT CLEARLY USING BLACK INK

Referral to:	**Referring Practitioner:**
Name: Address:	Name: Practice Stamp:

Patient Details:

Name: Date of Birth: / /

Address (including postcode):

Contact Telephone Number:

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

Section 1: Basic Information

If you are referring for treatment you will need to provide all the details below plus the information in Section 2.

		Yes	No
a	Is the patient motivated to undergo orthodontic treatment (wear appliance)?		
b	Is the patient a low caries risk with no active decay and has all necessary restorative care been completed?		
c	Is oral hygiene 'good' to 'excellent'?		
d	Have patient and parents had the benefits and risks of orthodontic treatment explained to them?		

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

		Yes	No
e	Is the patient in/very nearly in permanent dentition?		

If patient is in primary dentition or early mixed dentition, please state reason for early referral (eg impacted permanent canine, cross bite with displacements, craniofacial anomalies etc):

Referral For (Please tick one):

Advice Only *(Complete Section 3 & 4)* ☐ Assessment & Treatment Plan *(Complete Section 3 & 4)* ☐ Assessment & Treatment *(Complete Section 2 & 4)* ☐

Please ensure all relevant radiographs are included

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Section 2: Referral For Treatment

This section must be completed if your referral is for treatment.

Please tick one or more appropriate feature OR provide an IOTN Score

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	Spaced (4mm or more contact point displacement) ☐	Severe (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 Ectopic Teeth ☐	***SEVERE JAW DISCREPANCIES*** ☐	***CLEFT LIP/ PALATE OR OTHER CRANIOFACIAL CONCERN*** ☐
IOTN (If known)	IOTN 5 ☐	IOTN 4 ☐	IOTN 3 with AC 6 or above ☐	

*Features in **BOLD** and **UPPERCASE** should be referred to a Consultant in Orthodontics in your local hospital. Other IOTN 4 and 5 cases may be accepted by the orthodontic department at the local hospital. Referrers are advised to liaise with their local consultant in orthodontics before referring such cases.*

Section 3: Advice and/or Treatment Planning

If the patient is being referred for advice and/or treatment planning, it is assumed that you will be providing the required NHS treatment to the patient. Please indicate the nature of the advice required and/or your provisional treatment plan (to be confirmed by the specialist/consultant) *e.g. URA to correct crossbite or space maintainer* :

Section 4: Other Information: *Please attach additional information, if necessary*

Relevant Dental History (if urgent please specify):

Relevant Medical History and GP's name:

Relevant Social History:

Referring Dental Practitioner's Signature: _____ **Date:** _____

Name: _____ **Performer Number:** _____