**Orthodontic Department**

**Charles Clifford Dental Services Referral Form**

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| --- | --- |
| Patient name Click here to enter text.Title Click here to enter text. Female ☐ Male ☐ Date of Birth Click here to enter text.Address\_Click here to enter text.Post code Click here to enter text.Home Telephone Click here to enter text.Mobile Click here to enter text.NHS number Click here to enter text. | Referrer name Click here to enter text.**V. Code** (Dental Practices) Click here to enter text.Address Click here to enter text.Post Code \_Click here to enter text.Tel No Click here to enter text.E mail address Click here to enter text. |
| GP Name & Address |

Date Click here to enter a date. Interpreter required ☐

 Language Click here to enter text.

|  |
| --- |
| **Reason for referral**  |
| **Medical History**  |
| **Previous types of radiographs taken** | **Dates Taken** | **OPT/cephalometric radiographs enclosed**  |
|  |  | Yes ☐ No ☐ |
| **Is the patient caries free?** | Yes ☐ No ☐ |
| **If not, what is your caries management plan?** |  |

**Is your referral for:**

|  |  |  |
| --- | --- | --- |
| Advice only | A treatment plan | Provision of treatment |
| **Do you think that the patient has a low IOTN score?** | Yes ☐ No ☐ |