Wickford Dental Practice 68 London Road Wickford Essex SS12 OAN

NHS Private



Tel 01268 761 638 Fax 01268 572 106

Patient Details: F		Referral fo	or Primary	Care Orth	odontic As	sessment	
Name:					DOB:		
					Tel No:		
Address:					Mobile:		
				Ref to: Sp	ecialist pra	ctitioner/	
				DWSI			
			Referral Information				
				Date of ref:			
Reasons for referral (tick as appropriate):							
Overjet 1-6mm		7mm and	over	,			
Openbite Ant		Lat/post		Crossbite			
Crowding: Mild		Moderate		Severe		Spaced	
Hypodontia:	1 tooth m	issing		> 1		Unsure	
Extreme open bites Cleft lip Advice regarding elective extractions in a child in need of ortho treatment Is patient in fully permanent dentition Can patient comply with normal dental treatment Is the patient's oral hygiene good? Does the patient want orthodontic treatment? Answering No to the above 4 questions may result in the referral being returned Please advise patient that eligibility for NHS treatment is based on IOTN and mild cases do not qualify. Please attach relevant radiographs and tick as appropriate							
	None				Intraorals		
	OPG				Lat ceph		
Dental practitioners signature							
Name of Dental Practitioner							
Practice stamp							

Please Note:

This form contains confidential patient information. This form must always be sent to a person, post holder or legitimate safe haven. If sent via external mail it must be sent via recorded delivery or NHS Courier. If sent via e-mail it must be sent from and to e-mail accounts with suitable encryption.