Dentaire
Dental Care

Private Orthodontic Referral Form

Date……………………………………

Referring Practitioner

Name………...
Address……...
Contact telephone number……………………..…………………………………………………………………
Email………...
Fax number………………………………………………………………………………………………………

Patient details

Name………………………………………………………………………….………… Male / Female (please circle)
Address……...
……………………………………………………………………... NHS No……………………………………………..
Postcode…………………………………………………………… Date of birth………………………………………
Contact telephone number………………………………………………………………………………………

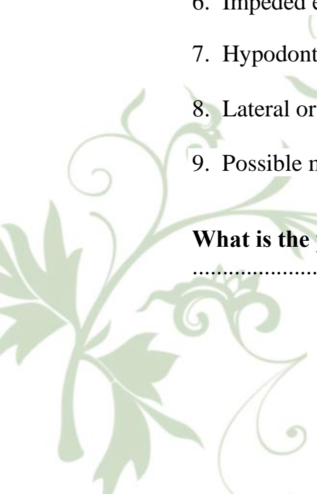
General Medical Practitioner – Dr ………………………………………………………………………………
Address of surgery ………………………………………………………………………………………………

Is the patient committed to wearing braces?	Yes	No
Does the patient have active caries?	Yes	No
Does the patient have good oral hygiene?	Yes	No

Relevant medical history:..

Please tick as many boxes as necessary that apply to the case

1. Unerupted canines in patient aged 12 years ☐
2. Overjet >3.5mm <6mm with incompetent lips ☐
3. Overjet >6mm ☐
4. Reverse overjet > -1mm ☐
5. Traumatic overbite ☐
6. Impeded eruption and impaction of teeth ☐
7. Hypodontia ☐
8. Lateral or anterior open bites ☐
9. Possible multidisciplinary case ☐
10. Anterior or posterior crossbites with displacement ☐
11. Supplemental teeth ☐
12. Severely displaced teeth >4mm ☐
13. Submerged deciduous teeth ☐
14. Severe crowding ☐
15. Private assessment ☐
16. GDP would like an opinion ☐



What is the patient's complaint?

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International Academy of Advanced Facial Aesthetics IAAFA
BDA goodpractice
British Dental Association accredited dental practice