Please complete the following referral form and return to:
mydentist Moor Allerton Advanced Oral Health Centre
Unit A Moor Allerton District Centre
Leeds
LS17 5NY

*Patient's Title	*Patient's Full Name:	*Sex:	*Date of Birth / /
*Patient's Full Address:		*Age of Patient: Years months	
*Patient's Postcode:	*Patient's preferred Contact Number:		

*Practice address		*Practice Postcode:
		*GDC Number of Referrer
*Date of decision to refer DD/MM/YY	*Practice telephone number:	NHS Number Mandatory
*Patient's GP Name and Address including postcode:		

If you are referring for treatment, please complete section 1, 2, 3 and 4.

If you are referring for advice only, please complete section 1, 3 and 4, including all relevant information in section 3.

Referrals will be returned to you if all the relevant information on this form is not completed (*)

Section 1

	Yes	No
a. *Is the patient motivated to undergo orthodontic treatment (attend multiple treatments and wear an appliance)?		
b. *Is the oral health stabilised and the patient has oral hygiene acceptable for orthodontic treatment?		
c. *Have the patient and parents been advised that they may not be eligible for NHS treatment?		
d. *Is the patient in/very nearly in permanent dentition? Or state reason for early referral below.		
e. *Has the patient had bitewing radiographs taken in the last 6 months and any treatment completed		

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

f. *Please complete a BPE**

*If patient is in primary dentition or early mixed dentition, please state reason for early referral (e.g. impacted permanent canine, crossbite with displacements, craniofacial anomalies etc.):

g. *Are permanent canines erupted (Yes/No)?

UR3	UL3	LL3	LR3

h. *If not erupted, please indicate if palpable buccally (B) / palatally (P) / non-palpable (N)

	UR3	UL3	LL3	LR3
B				
P				
N				

Section 2

This section must be completed if your referral is for treatment. Please complete table and IOTN

***You must be able to tick at least one of these boxes in order for your patient to qualify for treatment on the NHS.** Patients must be less than 18 years old on the date of assessment by the orthodontist to be eligible for NHS primary care treatment. If complex secondary care is indicated the patient can be over 18 years of age – you must provide additional details and refer to the hospital service directly using this form.								
Overjet	>3.5mm but <=6mm with incompetent lips		>6mm but <=9mm		**Greater than 9mm**		Reverse OJ >1mm Reverse OJ >3.5mm	
Overbite	Complete and potentially traumatic		**Extreme open bites lateral or anterior (greater than 4mm)**					
Crowding / Spacing	Moderate crowding (2mm or more contact point displacement)		Severe spacing / crowding (4mm or more contact point displacement)					
Hypodontia	Up to one tooth missing in any quadrant		**More than one tooth missing in any quadrant***		*Please complete additional information in Section 3 stating which teeth are missing. You may be asked to provide radiographs to determine if teeth are absent or impacted.*			
Other Clinical Features	**Ectopic/impacted teeth requiring intervention**		Crossbites anterior or posterior with displacement greater than 2mm		**Severe Jaw Discrepancies**		**Cleft lip / palate or other craniofacial concern**	
***Please state *your* assessment of IOTN?**	***Dental Health Component**		***Aesthetic Component**		*Details on IOTN scoring can be found on the LDI website where there is a simple guide to scoring as well as a copy of the aesthetic guidelines. DHC is scored from 1 – 5, Aesthetic from 1 through 10.*			
Please state any other feature not mentioned above e.g. supernumerary or submerged teeth.								

Section 3

Additional information

1) * **Medical history / special needs.**

Tick if none ☐

2) * **Please state reason for referral and patients complaint. If you are referring a patient aged 18 or older this should be to the hospital service. The case must be multidisciplinary in nature and you must provide justification here or attach additional sheets**

3) * **Any missing teeth record here**

Please confirm that:

☐ *The patient & parent / guardian understand NHS treatment is not guaranteed and will depend on need and assessment findings.

☐ *The patient and parent / guardian understand what is involved in orthodontic care, what their responsibilities are and what commitment is required from them to complete orthodontic treatment

☐ *Please confirm that you have explained the above to the patient and parent/guardian and that they agree to comply

Section 4

***Referring Dental Practitioner's Signature:**	***Date:**
***Name:**	***Performer number:**