

## NHS Orthodontic Referral Form

Please complete this form for any patient in need of NHS orthodontic treatment ensuring that they

- are aged over 8 years and under the age of 18 for routine treatment in Primary Care  
 meet the requirements of the Index of Treatment Need (IOTN) 5, 4 or 3 with an aesthetic component of 6 or above. Please complete index of orthodontic need (IOTN) on page 2.

TO AID YOUR GRADING OF THE IOTN PLEASE DOWNLOAD THE EASY IOTN APP:

**iPhone** <https://itunes.apple.com/gb/app/easy-iotn/id1144560762?mt=8>

**Android** [https://play.google.com/store/apps/details?id=com.vincentharding.EasyIOTN&hl=en\\_GB](https://play.google.com/store/apps/details?id=com.vincentharding.EasyIOTN&hl=en_GB)

1 <sup>st</sup> Preferred Provider	
2 <sup>nd</sup> Preferred Provider	

Please note all sections and information is mandatory - incomplete forms will be returned.

SECTION ONE – PATIENT DETAILS		SECTION TWO – REFERRER DETAILS	
First name		Date of referral	
Last name		Referrer Name	
Gender		GDC Number	
Date of birth		Signature	
NHS no.		Practice address:	
Patient address:			
Postcode		Phone	
Landline/mobile		NHS.net email	
Email			

### SECTION 3 – DETAILS OF GENERAL MEDICAL PRACTITIONER (GP)

GP Name:	GP Address:

### SECTION 4 – REASON FOR REFERRAL

Standard referral <input type="checkbox"/>	Other (please advise below) <input type="checkbox"/>
Second Opinion <input type="checkbox"/>	
Transfer <input type="checkbox"/>	

## Index of Orthodontic Need (IOTN)

Please complete this form for any patient requiring NHS orthodontic treatment that meets the following criteria. Patients must meet the requirements of the Index of Treatment Need (IOTN) 5, 4 or 3 with an aesthetic component of 6 or above to be eligible for NHS treatment.

**PLEASE TICK IN THE WHITE SPACE NEXT TO THE APPROPRIATE BOX**

	IOTN SCORE	5	4	3	2
	NEED FOR TREATMENT	Very Great	Great	Moderate	Little
a	Overjet	>9mm <input type="checkbox"/>	6-9mm <input type="checkbox"/>	3.5-6mm Incompetent lips <input type="checkbox"/>	3.5-6mm Competent lips <input type="checkbox"/>
b	Reverse overjet	<input type="checkbox"/>	>3.5mm <input type="checkbox"/>	1-3.5mm <input type="checkbox"/>	<1mm <input type="checkbox"/>
c	Cross bite	<input type="checkbox"/>	>2mm <input type="checkbox"/>	1-2mm <input type="checkbox"/>	<1mm <input type="checkbox"/>
d	Tooth displacement	<input type="checkbox"/>	>4mm <input type="checkbox"/>	2-4mm <input type="checkbox"/>	1-2mm <input type="checkbox"/>
e	Open bite	<input type="checkbox"/>	>4mm <input type="checkbox"/>	2-4mm <input type="checkbox"/>	1-2mm <input type="checkbox"/>
f	Over bite	<input type="checkbox"/>	Increased complete & trauma <input type="checkbox"/>	Increased/complete & no trauma <input type="checkbox"/>	<3.5mm incomplete, no trauma <input type="checkbox"/>
g	Pre/post normal occlusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	½ unit discrepancy <input type="checkbox"/>
h	Hypodontia Missing teeth	>1 tooth per quadrant <input type="checkbox"/>	Less severe <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i	Impeded eruption	Due to crowding, displacement, pathology <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l	Posterior/ Lingual cross bite	<input type="checkbox"/>	No functional occlusion <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m	Reverse overjet	>3.5 with speech or masticatory problems <input type="checkbox"/>	>1-3.5 with speech or masticatory problems <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p	Cleft lip & palate	Yes <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
s	Deciduous teeth	Submerged <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
t	Partially erupted	<input type="checkbox"/>	Tipped or Impacted <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
x	Supplemental	<input type="checkbox"/>	Supplemental <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IOTN N/A	Caries or trauma with doubtful prognosis <input type="checkbox"/>	Monitoring growth <input type="checkbox"/>	Orthognathic <input type="checkbox"/>	Digit habit <input type="checkbox"/>
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**PLEASE CONFIRM THE FOLLOWING:**

The patient is motivated to wear appliances

YES NO

Oral Hygiene is EXCELLENT

The patient is dentally fit and caries free confirmed by bite wings

Unless this is a formal second opinion, there has been no previous orthodontic referral

Radiographs included – bite wings

Radiographs included – OPG

Does the patient require a translator?

**Referrals will be returned to the referring practitioner if all relevant information on this form is not complete.**