Please return fully completed forms to **ONE** of the providers listed on the SW NHS website: [https://www.england.nhs.uk/south/info-professional/dental/](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fsouth%2Finfo-professional%2Fdental%2F&data=05%7C01%7Cclare.mcnamara3%40nhs.net%7C429d45e93bb94b4d7e8208daf307c244%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638089511890465732%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=F2PCVVfc77cz1hw9K1b%2BSx5gnF1c2jvU%2Be6LB7XGH1o%3D&reserved=0)

or the NHS Future’s Platform <https://future.nhs.uk/SouthWestDental/grouphome>

(multiple referrals to different providers will be automatically rejected by all providers)

**All Dorset** referrals to be made via Rego: <https://ref.management/login>

|  |  |
| --- | --- |
| **SECTION 1: PATIENT DETAILS** | **SECTION 2: REFERRER DETAILS** |
| Name:Date of birth:Gender: NHS no:Address:Postcode:Phone no:Email address: Safeguarding concerns: **YES** ☐ **NO** ☐Details: | Name:GDC number:Practice name:Practice address:NHS email address:**PATIENT GDP details** (if not the referrer)GDP name:Practice name:Practice address: |
| **SECTION 3: MEDICAL HISTORY/SOCIAL DETAILS** |
| **MEDICAL HISTORY:**  **YES** [ ]  **NONE** [ ] Please detail below:  | **MEDICATION LIST:**  **YES** [ ]  **NONE** [ ] Please detail below:  |
| **ALCOHOL INTAKE:**  **YES** [ ]  **NONE** [ ] Please detail below:  | **SMOKER/VAPER/EX-SMOKER:**  **YES** [ ]  **NONE** [ ] Please detail below:  |
| **ALLERGIES:**  **YES** [ ]  **NONE** [ ] Please state allergy and description of reaction, if known.  | **OTHER INFORMATION** (e.g. living arrangements, legal guardian) |
| **SECTION 4: PATIENT GMP DETAILS** (if not the referrer) |
| GMP name (if known):Practice name: | Practice address:NHS e-mail address: |
| **SECTION 5: COMMUNICATION & ADDITIONAL REQUIREMENTS** |
| Does the patient communicate in a language or mode other than English? **YES** [ ] please detail below **NO** [ ] Is an interpreter required? **YES** [ ]  **NO** [ ] Please detail below  | Does the patient have any additional requirements (e.g. sight/hearing/neurodiversity/high anxiety)? **YES** [ ] please detail below **NO** [ ]   |
| **SECTION 6: REFERRAL INFORMATION** |
| **Date of referral:** **Referring to\*:**\*Select ONE of the providers listed on the SW NHS website <https://www.england.nhs.uk/south/info-professional/dental/> | **Referral type:** Urgent**\*** [ ] Routine[ ] Opinion only[ ] Opinion & Treatment[ ] **\***please justify in the information box on next pageType of referral (please tick)**A) New Referral** [ ] **B) Second Opinion** [ ] **C) Transfer case** [ ]  |
| **Has the patient had previous orthodontic treatment?****NO** [ ]  **YES\*** [ ] \*please provide details in section 10. |
| **SECTION 7: REASON FOR REFERRAL**Please tick **one** box only. Please note the **yellow** boxes indicate that a hospital referral is required. |
| **IOTN SCORE** | **5** | **4** | **3** |
| **NEED FOR TREATMENT** | **Very Great** | **Great** | **Moderate** |
| **a** | **Overjet** | [ ] >9mm | [ ] 6.1-9mm | [ ]  3.5-6mm Incompetent lips |
| **b** | **Reverse overjet** |  | [ ] >-3.5mm | [ ]  -1 to - 3.5mm |
| **c** | **Crossbite** |  | [ ] >2mm | [ ]  1-2mm |
| **d** | **Tooth displacement** |  | [ ] >4mm | [ ]  2-4mm |
| **e** | **Openbite** |  | [ ] >4mm | [ ]  2-4mm |
| **f** | **Overbite** |  | [ ]  Increased complete & trauma | [ ]  Increased/complete & no trauma |
| **h** | **Hypodontia****Missing teeth** | [ ]  >1 tooth per quadrant(excluding third molars) | [ ] Up to 1 tooth per quadrant |  |
| **i** | **Impeded eruption** | [ ]  e.g. ectopic and unerupted canine | Specialist Practice [ ] Hospital [ ]   |
| **l** | **Posterior/****Lingual crossbite** |  | [ ]  No functional occlusion |  |
| **m** | **Reverse overjet** | [ ]  >3.5 with speech or masticatory problems | [ ] >1-3.5 with speech or masticatory problems |  |
| **p** | **Cleft & Craniofacial** | [ ]  Yes |  |
| **s** | **Primary teeth** | [ ]  Infra-occluded | Specialist Practice ☐ Hospital ☐ |
| **t** | **Partially erupted** |  | [ ] Tipped or impacted |  |
| **x** | **Supernumerary** |  | [ ] Supernumerary |  |
| **SECTION 8: MAXILLARY CANINES**(This section must be completed, or the referral will be rejected) |
| Are both upper permanent canines erupted/palpable in the correct position by age 10? YES [ ]  NO\* [ ]  **\*If NO, the canine may be ectopic, please provide radiograph(s)** **Advise date radiograph taken:** |
| **SECTION 9: HOSPITAL OR MDT REFERRALS** |
| [ ] Patient with medical developmental or social problems needing hospital care | [ ] Patient needing orthognathic MDT(e.g. significant skeletal discrepancies) | [ ] Patient needing ortho and oral surgery MDT (e.g. multiple impacted teeth) | [ ] Patient with complex problems needing ortho and restorative dent MDT  |
| **SECTION 10: INFORMATION TO SUPPORT REFERRAL** (Please attach additional sheets if necessary) |
|  |
| **SECTION 11: SUITABILITY OF PATIENT FOR REFERRAL** |
| Patients should only be referred after the following has been achieved. Please tick to confirm:[ ]  Patient has an excellent level of oral hygiene [ ]  Patient is caries free and/or caries have been stabilised[ ]  To avoid repeating images, high quality print/DICOM file(s) of relevant radiographs have been included/emailed to provider? |
| **Print Name** |  | **Signature** |  | **Date** |  |