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 onlyOpinion & Treatment  **\***please justify in the information box on next page  Type 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** |  |