



Orthodontic Referral Form

REFERRING DENTIST

Name: _____ Tel: _____
Address: _____ Fax: _____
_____ Email: _____
Post code: _____ Date: ____ / ____ / ____

PATIENT DETAILS

Name: _____ Home Tel: _____
Address: _____ Work: _____
_____ Mob: _____
Post code: _____ D.O.B.: ____ / ____ / ____

Is this referral urgent? Yes No

RELEVANT MEDICAL HISTORY (Any additional comments about this referral)

Health care no: _____

TYPE OF REFERRAL (Please tick)

Patient new to your practice Regular Attender

REASON FOR REFERRAL (Please tick/specify)

Consultation Advice or Treatment Plan NHS Orthodontics Private Orthodontics

Deciduous Dentition Mixed Dentition Permanent Dentition

GENERAL

Has the patient been made aware of the level of investment that may be required? Yes No

CHI NUMBER

Please provide CHI Number: _____

Please be assured that we will neither approach nor accept your patient for non-referred treatment.