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*

1st Preferred Provider	
2nd Preferred Provider	

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

SECTION ONE – PATIENT DETAILS	
First name	
Last name	
Gender	
Date of birth	
NHS no.	
Patient address:	
Postcode	
Landline/mobile	
Email	

SECTION TWO – DETAILS OF REFERRER	
Referrer Name	
GDC Number	
Signature	
Date of referral	
Practice address:	
Phone	
Email (preferably NHS.net)	

SECTION 3 – DETAILS OF GENERAL MEDICAL PRACTITIONER (GP)	
GP Name:	GP Address:

SECTION 4 – REASON FOR REFERRAL	
Standard referral ☐	Other *(please advise below)* ☐
Second Opinion ☐	
Transfer ☐	

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

IOTN N/A	Caries or trauma with doubtful prognosis		Monitoring Growth		Orthognathic	

PLEASE CONFIRM THE FOLLOWING:	YES	NO
The patient is motivated to wear appliances	☐	☐
Oral Hygiene is EXCELLENT	☐	☐
The patient is dentally fit and caries free confirmed by bite wings	☐	☐
That there hasn't been a referral to another orthodontist (unless a formal second opinion)	☐	☐
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.