REFERRAL FORM

ELSEY & ELSEY
DENTAL CLINIC

PATIENT	DENTIST
Name	Name
D.O.B.	Address:
Address:	Tel:
Tel:	Fax:
Email:	Email:

Date of referral:

Type of referral: (please circle) NHS Private

In order to help prioritise referrals effectively and to ensure your patient is seen at the correct time, please tick as many as apply:

Increased overjet	☐	Crowding	☐	Impacted teeth	☐
Crossbites	☐	Molars (poor prognosis)	☐	Irregular eruption pattern	☐
Spacing	☐	Hypodontia	☐	Cannot Palpate canines (patient aged 10+)	☐
Supernumerary	☐	Submerging teeth	☐		

Any other relevant information?

Radiographs sent: (please circle) Yes* No

*If yes please indicate type and number of radiographs:

REFERRAL GUIDE

Most orthodontic treatment is carried out for children aged 10 years+, and once the permanent dentition is established Exceptions to this rule, when referral in the mixed dentition is appropriate, are:

- Anterior or posterior crossbites
- Asymmetry in the pattern of tooth eruption (e.g. a lateral incisor erupts before a central)
- Molars of Poor Prognosis (seek opinion before extracting)
- Lack of palpable canine bulges buccally (age 10+)
- Hypodontia
- Supernumerary teeth
- Submerging deciduous molars
- Impacted teeth

Otherwise, please delay referral until the first premolars have erupted

Thank you for your referral.

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