

**South Central West Orthodontic Managed Clinical Network
Referral For NHS Orthodontic Assessment**

Please complete all sections of this form. Incomplete forms will be returned.

Please complete this form for any patient aged over 8 years of age and in need of NHS orthodontic treatment that meets the following criteria. He/She:

1. meets the requirements of the Index of Treatment Need (IOTN) 5, 4 or 3 with an aesthetic component of 6 or above.
2. is under the age of 18 for routine treatment in Primary Care.

Please include a copy of any relevant radiographs.

SECTION ONE – PATIENT DETAILS

Patient Name: _____	GDP Details: _____
Date of Birth _____	_____
Address and Postcode: _____	_____
_____	_____
_____	_____
Telephone Numbers: _____	_____
Home: _____	GMP Details: _____
Mobile: _____	_____
Work: _____	_____
Email: _____	_____

SECTION TWO – DETAILS OF REFERRER

As the referring practitioner, I confirm that

- The patient is aware of waiting times for their preferred providers.
- I am confident that the patient meets the referral conditions and has an understanding of the commitment required to undertake a course of orthodontic treatment.

Please see British Orthodontic Society Easy IOTN App for further information

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SECTION THREE – REFERRAL HISTORY

SECTION FOUR – REASON FOR REFERRAL

For Office Use

Date Received: _____

Enclosures Received

Routine / Urgent / Reject

Signature: _____

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For reference only

IOTN Score		5	4	3	2
Need for treatment		Very Great	Great	Borderline	Little
a	Overjet	>9mm	6-9mm	3.5-6mm incompetent	3.5-6mm competent
b	Reverse overjet		>3.5mm with NO speech or masticatory problems	1-3.5mm	<1mm
c	Crossbite		>2mm	1-2mm	<1mm
d	Tooth displacement		>4mm	2-4mm	1-2mm
e	Openbite		>4mm	2-4mm	1-2mm
f	Overbite		Increased, complete & traumatic	Increased, complete & no trauma	<3.5mm incomplete, no trauma
g	Pre or post normal occlusion				½ unit discrepancy
h	Hypodontia	>1 tooth per quadrant	1 tooth per quadrant		
i	Impeded eruption	Crowding, displacement, pathology			
l	Posterior, lingual crossbite		No functional occlusion		
m	Reverse overjet	>3.5mm with speech and masticatory problems	1-3.5mm with speech and masticatory problems		
p	Cleft lip and palate	Yes			
s	Deciduous teeth	Submerged			
t	Partially erupted		Impacted		
x	Supplemental		Supplemental		
IOTN N/A		Teeth with Caries or Trauma with doubtful prognosis, monitoring growth, orthognathic surgery			

Patients in blue zones including patients with a Cleft Lip and Palate– refer to Hospital Service
 Patients in green zones – refer to either Hospital Service (Consultant, Training Grades and DwSI) or Specialist Practice or DwSI for assessment
 Patients in orange zones where aesthetic component is 6 or above – refer to Specialist Practice or DwSI for assessment
 Patients in red zones are not eligible for NHS treatment

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