Referral form for NHS orthodontics

For you.... for life

RESOLUTION
Specialist Treatment Centre

Please complete and send to:

Dr M R Brickley
Resolution Specialist Treatment Centre
Becket House, Hendford
YEOVIL, Somerset
BA20 1TE

Or email: mail@resolutionsmile.com

Referring Dentist :

Name: _____

Practice: _____

_____

_____

_____

Tel: _____

Email:_____

N.B Patient must be under 18

Referral DATE : _____

PATIENT MALE / FEMALE (please delete)

NAME : _____ DOB: _____

ADDRESS: _____

_____

POSTCODE:

_____

TEL: MB: EMAIL

PLEASE TICK REASON FOR REFERRAL

☐ **Significant orthodontic abnormality**

- ☐ **IOTN 3 or below**
- ☐ **IOTN 4 OR 5**

☐ **Extraction Advice Required**

☐ **Teeth with poor prognosis**

☐ **Significant patient or parental concern**

☐ **Already wearing appliances**

☐ **Second Opinion**

RADIOGRAPHS ☐ **Tick if radiographs enclosed**

RELEVANT DENTAL INFORMATION please tick which apply

Oral Hygiene **Good** ☐ **Average** ☐ **Poor** ☐ **High Caries** ☐ **Fluoride Supp'ts** ☐ **Erosion** ☐

FURTHER COMMENTS

SIGNATURE OF DENTIST (or designated party) .....