wearside orthodontic centre

NHS

Wearside Orthodontic Centre Referral Form

Patient Details

Name

Date of Birth

Address

Postcode

Telephone No.

NHS No. if known:

Interpreter Needed? ☐ YES ☐ NO

Name of parent/guardian

Referrer Details

Name

Address

Postcode

Telephone No.

GMP

GMP Address

GMP Postcode

Relevant Medical History

General Assessment of Dental Health

Dental History

Attendance: ☐ Regular ☐ Infrequent ☐ 1st Visit

Co-operation

Oral Hygiene

IOTN DH: ☐ 3 ☐ 4 ☐ 5 AC:

My dentist has explained why I/my son/daughter has been referred for an orthodontic assessment. I understand what is involved and am interested in supporting them in having necessary treatment.

Patient's / Parent Signature:

Date:

Reason for Referral

Patient's Concern/Complaint

Patient's Motivation: ☐ Good ☐ Poor

Radiographs Included ☐ YES ☐ NO

Please return to:

Referrals Coordinator
Wearside Orthodontic Centre
49 Frederick Street
Sunderland SR1 1NF

Signed:

Date:

If you would like more referral forms please tick here ☐

For WOC Use Only:

Received:

Appointment Date/Time:

BDA goodpractice

INVESTORS IN PEOPLE