CONFIDENTIAL

Orthodontics Specialist Referral Form

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Referring General Dental Practitioner details:

Name: _____

Job Title: _____

Practice: _____

Address: _____

_____ Postcode: _____

Tel(s)/ext.: _____

Please take a photocopy of this form before you return it to us by post

Date of referral: D D / M M / Y Y Y Y

Preferred clinician: NOOR AL-MANSOURI

Patient's details (BLOCK CAPITAL LETTERS PLEASE):

Title: **Mr/Miss/Mrs/Ms/Other:** _____ Date of Birth*: D D / M M / Y Y Y Y

Surname*: _____ **First name*:** _____

Gender: Male / Female

Address*: _____

_____ Postcode*: _____

Mobile*: __ __ __ __ __ __ __ __ __ __ __ Telephone: __ __ __ __ __ __ __ __ __ __ __

Email: _____

DENTAL HISTORY

Oral hygiene (circle): poor / fair / good

Reason(s) for referral:

Significant orthodontic abnormality ☐

Already wearing appliances ☐

Other ☐

If other, please give details below:

_____

_____

_____

_____

_____

Relevant information:

Enclosure(s):

Radiographs ☐ Medical history ☐

Other

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 any necessary orthodontic care.

Patient's / Parent's signature: _____ Date: D D / M M / Y Y Y