AR Smiles
416 Well Hall Road
Eltham
SE9 6UD
Tel: 0208 856 7759

Orthodontic Referral Form

If you answer no to **ANY** of the below questions, please **DO NOT** refer to the in-house orthodontist:

1. *Is the patient above 12 years old? Yes/No… if the answer is no, please refer to the hospital if you think early intervention is necessary*
2. *Is the oral hygiene good? Yes/No… If the answer is no, book an oral hygiene review* ***Patient must only be referred when oral hygiene is good***
3. *Is the patient keen for orthodontic treatment and able to cooperate sufficiently? Yes/No*

PATIENT DETAILS:

Patient's name:

Patient's Date of Birth:

Address:

Telephone number:

Reason for referral:

(If the patient has severe malocclusion and likely to need surgery, impacted canines or needs an opinion on 6's, please refer to hospital orthodontics)

Dentist name:

……

GDC number:

……

Dental practice name and address:

……

……

Dental practice contact number:

……

Dental practice email address:

……