Wessex Orthodontic Referral Form

1st Preferred Provider	
2nd Preferred Provider	

1. **Please complete all sections. Incomplete forms will be returned.**
2. This form should be filled in electronically and then printed. Please do not refer without following both the Orthodontic Referral Pathway and IOTN Guidance documents which can be found at the Solent NHS Trust Website: www.solent.nhs/dental
3. Please return the completed form to Orthodontic Referral Centre (CRC), Solent NHS Trust, Single Point of Access, Level A, Royal South Hants Hospital, Brintons Terrace Southampton SO14 0YG Tel: 023 8071 6695 Fax: 023 8071 3279
4. This form should be used for patients aged 8 and under the age of 18 years. For patients outside of this criteria please see Referral Guidance.

SECTION ONE - PATIENT DETAILS *(this information is mandatory. If this section is incomplete the referral will be returned to the referrer concerned)*

First name	
Last name	
Gender	
Dob	
NHS no.	
Address	
Postcode	
Landline/Mobile	
Email	

SECTION TWO - DETAILS OF REFERER *(this information is mandatory. If this section is incomplete the referral will be returned to the referrer concerned)*

Referrer name	
GDC no.	
Signature	
Date of referral	
Practice address	
Phone	
Email (preferably NHS.net)	

As the referring dentist, I confirm that: (tick all appropriate)

- ☐ The patient is aware of waiting times for their preferred providers (available at: http://www.solent.nhs.uk/waitingtimes
- ☐ I have read the appropriate NHS England - South (Wessex) Orthodontic Referral Pathway, the IOTN Guidance and the Frequently Asked Questions (FAQs) and I am confident that the patient meets the referral conditions.
- ☐ I confirm that the NHS contract holder/lead clinician is in agreement for this referral to be made
- ☐ I have undertaken recent IOTN training

I enclose a recent OPG x-ray: YES ☐ NO☐

SECTION THREE – DETAILS OF GENERAL MEDICAL PRACTITIONER (GP) (*This information is mandatory. If this section is incomplete the referral will be returned to the referrer concerned).*

GP Name & Address		

Reason for referral (tick relevant)

- ☐ Standard referral
- ☐ Second Opinion
- ☐ Transfer of Care
- ☐ Other (give details)

Index of Orthodontic Treatment Need (IOTN)

WESSEX ORTHODONTIC MANAGED CLINICAL FRAMEWORK

Patient Name: **Date of Birth:**

Please complete this form for any patient requiring NHS orthodontic treatment that meets the following criteria. Patients must meet the requirements of the Index of Treatment Need (IOTN) 4, 5 and 3 with an aesthetic component of 6 or above to be eligible for NHS treatment. Patients must be aged 8 and under the age of 18 at the point of referral. PLEASE TICK NEXT TO THE APPROPRIATE COLOURED BOX

	IOTN SCORE	5		4		3		2	
	NEED FOR TREATMENT	Very Great		Great		Moderate		Little	
a	Overjet	>9mm	☐	6-9 mm	☐	3.5-6mm Incompetent lips	☐	3.5-6mm Competent lips	☐
b	Reverse overjet			>3.5mm	☐	1-3.5mm	☐	<1mm	☐
c	Cross bite			>2mm	☐	1-2mm	☐	<1mm	☐
d	Tooth displacement			>4mm	☐	2-4mm	☐	1-2mm	☐
e	Open bite			>4mm	☐	2-4mm	☐	1-2mm	☐
f	Over bite			Increased complete & trauma	☐	Increased/ complete & no trauma	☐	<3.5mm incomplete, no trauma	☐
g	Pre/post normal occlusion							½ unit discrepancy	☐
h	Hypodontia	>1 tooth per quadrant	☐	Less severe	☐				
i	Impeded eruption	Due to crowding, displace-ment, pathology	☐						
l	Posterior/lingual cross bite			No functio- Occlusion	☐				
m	Reverse overjet	>3.5	☐	1- 3.5					
p	Cleft lip & palate	Yes ☐ No ☐	☐						
s	Deciduous teeth	Submerged	☐						
t	Partially erupted			Tipped or Impacted	☐				
x	Supplemental			Supplement al	☐				

IOTN N/A	Caries or trauma prognosis	with doubtful	☐	Monitoring Growth	☐	Orthognathic	☐

Patients in blue (very great need) zones – referral to hospital
Patients in green (great need) zones – referral specialist practice for assessment
Patients in yellow (moderate need) zones – referral to specialist practice for assessment where aesthetic component is 6 or above
Patients in red (little/no need) zones are not eligible for NHS treatment