Birmingham Orthodontic Managed Clinical Network – Referral Form

PATIENT AND PRACTICE DETAILS		
Patient's Name:		Name of GDP & Practice Details:
Patient's Address: Postcode		
Patient's Telephone No:		
Patient's D.O.B:	Gender:	

CLINICAL DETAILS	
Relevant Medical History	Relevant Dental History
Main Reason for Referral	

PATIENT TO BE REFERRED TO:	**REQUEST FOR**	**PLEASE ENSURE THAT PATIENTS BEING REFERRED FOR ACTIVE TREATMENT:**
Hospital Unit Specialist Practice	Assessment Advice for a straightforward treatment plan (preventive or interceptive) Comprehensive Treatment Plan Second Opinion	Are dentally fit and have good oral hygiene Are at the correct age Have a clear understanding of what treatment involves

Recent Radiographs Yes / No ……..

Has the patient been referred elsewhere in the last 12 months? Yes / No

Referring Practitioner Name…… Referring Practitioner Signature……..
Date……

PLEASE READ THE ACCOMPANYING GUIDANCE AND SELECT THE APPROPRIATE ORTHODONTIC PROVIDER TO SEND THIS REFERRAL FORM TO