BLACKBURN ORTHODONTICS

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Specialist Orthodontist
DCD (Orthodontics), DDS (Distinction), BOptom, AOB Cert

ORTHODONTIC REFERRAL FORM

Date
MM / DD / YYYY

Patient name _____

Date of birth _____ Phone number _____

Parent or guardian name _____

Patient address _____

_____

Referring practice _____

Referring practitioner _____

Referrer contact _____

Reason for referral

- ☐ Orthodontic evaluation & management
- ☐ Early/interceptive treatment
- ☐ Orthognathic surgery evaluation
- ☐ Clear aligner/Invisalign
- ☐ Lingual/aesthetic braces
- ☐ Other

Clinical findings

- ☐ Class II
- ☐ Class III
- ☐ Open bite
- ☐ Overbite
- ☐ Overjet
- ☐ Crowding
- ☐ Airway concerns
- ☐ Missing teeth
- ☐ Crossbite/functional shift
- ☐ Impacted teeth
- ☐ Spacing
- ☐ Other

Date of last dental & periodontal examination

_____

Comments

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Signature

_____

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