Orthodontic Department

Charles Clifford Dental Services Form

PLEASE NOTE YORK AND HUMBER REFERRALS MUST BE MADE THROUGH e-RMS

Patient name Click here to enter text.Title Click here to enter text. Female ☐ Male ☐ Date of Birth Click here to enter text. Address_Click here to enter text. Post code Click here to enter text. Home Telephone Click here to enter text. Mobile Click here to enter text. NHS number Click here to enter text.	Referrer name Click here to enter text. **V. Code** (Dental Practices) Click here to enter text. Address Click here to enter text. Post Code _Click here to enter text. Tel No Click here to enter text. E mail address Click here to enter text.
GP Name & Address	

Date Click here to enter a date.

Interpreter required ☐

Language Click here to enter text.

Reason for referral		
Medical History		
Previous types of radiographs taken	**Dates Taken**	**OPT/cephalometric radiographs enclosed**
		Yes ☐ No ☐
Is the patient caries free?	Yes ☐	No ☐
If not, what is your caries management plan?		

Is your referral for:

Advice only	A treatment plan	Provision of treatment
Do you think that the patient has a low IOTN score?		Yes ☐ No ☐