

**ORTHODONTIC REFERRAL FOR CATHERINE McCANNY**

**DATE OF REFERRAL**

**REFERRING DENTIST**

Practice Telephone No:

E-Mail Address:

**PATIENT DETAILS**

SURNAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

POSTCODE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_

TELEPHONE NUMBER (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_

MEDICAL HISTORY \_\_\_\_\_

**PATIENTS COMPLAINT (PLEASE TICK)**

- |  |   |
|--|---|
| <input type="checkbox"/> APPEARANCE OF MAXILLARY ANTERIOR TEETH  | <input type="checkbox"/> DEEP BITE                    |
| <input type="checkbox"/> APPEARANCE OF MANDIBULAR ANTERIOR TEETH | <input type="checkbox"/> IMPACTED TEETH               |
| <input type="checkbox"/> TOP TEETH STICK OUT (OVERJET)           | <input type="checkbox"/> DIFFICULTY/PAIN WHEN CHEWING |
| <input type="checkbox"/> GUMMY SMILE                             | <input type="checkbox"/> MISSING TEETH                |
| <input type="checkbox"/> OPEN BITE                               | <input type="checkbox"/> OTHER _____                  |

**DETAILS OF MALOCCLUSION (PLEASE TICK OR DETAIL)**

OVERJET     0-6 mm     6-12mm     > 12mm

CROSSBITE     NONE     ANTERIOR     POSTERIOR  
 NO DISPLACEMENT ON CLOSURE  
 DISPLACEMENT ON CLOSURE

MAXILLARY CANINE POSITION  
 BUCCAL     PALATAL     UNSURE

STAGE OF DENTAL DEVELOPMENT  
 DECIDUOUS     MIXED     PERMANENT

PLEASE DETAIL

TEETH WITH POOR PROGNOSIS

TEETH WITH HISTORY OF TRAUMA

MISSING TEETH

IMPACTED TEETH
