The Essex Dental Clinic

Orthodontic Assessment Referral Form
Please note this is Private, all patients will need a consultation first

Male/Female	**Patient Name:**	**Date of Birth:**
Address:		**Tel No:**
		Mobile:
Date of Referral:		

Reason(s) for referral	**Indicate if Relevant (X)**	**Comments/Details?**
Impacted teeth		
Developmentally missing teeth		
Overjet		
Crossbites		
Crowding		
Overbite		
Craniofacial (Cleft lip and Palate/Others)		
Special Needs (including medical conditions)		

Is the patient in the permanent dentition stage?	Yes/No
Is the patient's oral hygiene good?	Yes/No
Is the patient willing to have orthodontic treatment?	Yes/No

Referral to: Mrs Urszula Grzegorczyk
The Essex Dental Clinic, The Business Centre, Earls Colne Business Park, Earls Colne, CO6 2NS TEL:01787222828 Please send referrals to: theessex.dentalclinic@nhs.net

Dental Practitioners Signature	Practice Address & Telephone Number
Name of Dental Practitioner	