



# specialist orthodontic referral form

If you wish to submit a referral online or accompanying radiographs please use the link:  
[www.lhdpsmilecare.co.uk/referrals](http://www.lhdpsmilecare.co.uk/referrals)

## Practice Details

Referring Dentist: \_\_\_\_\_ Date Referred: \_\_\_\_\_  
Referring Practice: \_\_\_\_\_

## Patient Details

Mr  Mrs  Ms  Miss  Other Patient's Name: \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
Telephone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Mobile: \_\_\_\_\_  
Email: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Is this referral urgent?  Yes  No

## Reason for Referral (please cross all relevant boxes)

Opinion only  
 Orthodontic treatment  
 Re-treatment  
 Other (please specify below)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Brief History / Comments About This Referral

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Investigations (already carried out)

OPG  PA's  Other Radiographs  Are these enclosed?  \_\_\_\_\_  
Has the patient been advised there will be a private fee for any treatment carried out  Yes  No  
Has the patient been informed on the location of LHDP Referral Centre  Yes  No