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|  | **Dental Services Referral Form- ORTHODONTICS**  **Date:** |

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| **DRN/UR** | **Title:** | **Surname** | **Given name** | **Date of birth:** |
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| **Street address** | **Suburb** | **Postcode** |
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| **Name of Residential Facility (if applicable)** | | |
| Room: | | |

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| **Phone - Home:** |  | **Mobile:** |  | **Work:** |  |

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| **Country of birth:** |  | **Cultural background:** |  |

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| **Needs interpreter:** | **Yes  No** | **Language:** |  |
| **Indigenous status:** |  | | |
| **Priority access:** |  | | |

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| **Concession Card type:** |  | | |
| **Concession Card No:** |  | **Expiry date:** |  |
| **Medicare Card:** | Patient no. | | |
| **Medicare Card No:** |  | **Expiry date:** |  |

**For Under 18 patients:**

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| **Parent/Guardian name(s):** |  | | |
| **Relationship to patient:** |  | **Phone:** |  |
| **School:** |  | | |

**For patients unable to provide self-consent:**

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| **Person Responsible name:** |  | | |
| **Relationship to patient:** |  | **Phone:** |  |
| **Address:** |  | | |

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| **ORTHODONTIC UNIT - OVERVIEW** |
| The Orthodontic Unit corrects teeth and jaw alignment problems using devices such as braces. Patients should be referred by the CDA which they attend for regular dental care. Patients are only accepted if there is a major improvement in oral health anticipated as a result of the treatment. The unit also provides advice to referring practitioners for treatments they can provide, such as extractions. |
| **SPECIALIST-IN-TRAINING TEACHING CASES – Consideration of Complex Cases** |
| RDHM is a teaching hospital and therefore a limited number of complex cases **may** be accepted for postgraduate training purposes. Training cases should align with the value-based health care principles in a public dentistry setting.  **Note:** There is no direct referral process to Postgraduate teaching programs. Case selection and acceptance will be considered separately for specialist-in-training.  This patient ***does not wish*** to be managed by Specialists-in-training. Time to treatment may be delayed if opted not to be seen by Specialists-in-training. |
| **CLINICAL CRITERIA FOR REFERRAL** |
| Patients are only accepted if there is a major improvement in oral health anticipated as a result of the treatment.  The Index of Orthodontic Treatment Need (IOTN) is used as a guide for screening patient treatment needs in this clinic. Only patients with IOTN grade 4 or 5 will be considered. |
| Patients with missing upper anterior teeth requiring pre-prosthetic orthodontics or orthodontic space closure to obviate the need for a prosthesis **may** also be accepted. |
| **EXCLUSION CRITERIA** |
| * Patients with cleft defects of lip and/or palate. These patients are covered by the Medicare Cleft Palate Scheme and can attend a private orthodontist or The Royal Children's Hospital: <https://www.rch.org.au/dentistry/> * Gingival bleeding on probing * Plaque index >20% * Patients who have active periodontal disease. These patients can only be treated once periodontal health **is** attained and they are in a maintenance phase’. |
| **INTERCEPTIVE ORTHODONTICS** |
| ***Patients in the mixed dentition phase may be considered for:***  Anterior or posterior crossbites when causing fremitus, gingival recession, tooth surface loss or deviation on closing  Ectopic eruption, impaction, non-eruption, infra-occlusion of teeth  Management of habits (initial cessation counselling must have been attempted and may include use of commercially available aids (e.g. bitter nail polish or thumb guard)  Do not take a lateral cephalogram if the patient is under the age of 12. If possible, please submit standard clinical photos of the dentition. Referrals screened by Orthodontics may be allocated to Paediatric Dentistry. |
| **PREREQUISITES FOR REFERRAL** |
| Completion of all other general dental care prior to referral  Excellent oral hygiene  If accepted for specialist care, patients must be prepared to attend The Royal Dental Hospital of Melbourne for multiple visits, often over many years. |

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| **Additional Information Required:** |
| Please tick applicable options for each requirement:  Current OPG (all cases) less than 12 months old  Lateral Ceph only in cases where there may be a skeletal discrepancy contributing to the malocclusion. (class 2, class 3, deep overbite, open bite) – ***FOR children over 12 years of age only***  Study models if the malocclusion is complex.   * Include an occlusal registration or mark the occlusion on the models * Ensure the models can occlude by removing excess plaster from the distal before it sets * Ensure the model is completely air-dry (at least 24 hours) before packaging and sending to RDHM, to prevent growth of mould on the model * Ensure the model is packaged to protect it from damage during shipping, e.g. Bubble Wrap®, or packed securely in carry boxes * Ensure each model is labelled correctly with the patient details, and on the outside of the packaging   Standard clinical photographs are preferred. Intraoral views: frontal, left and right lateral and occlusal: maxillary and mandible. Extraoral views: frontal at rest, frontal smiling, profile.  ***For adult patients:***  A periodontal assessment with recording of pocket depths, plaque index, recession and any bone loss  Measurements of all features of the malocclusion and a full description of any features not specifically requested on the referral forms |

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| **REASON FOR REFERRAL** |
| Examination and treatment  Opinion only  Telehealth |
| **Referral Urgency** |
| Referral indication of Urgency for Specialist Care (see Appendix to Referral to the Royal Dental Hospital of Melbourne Procedure)  Urgency 1  Urgency 2  Urgency 3 |
| **Patient’s / Person Responsible main concern / dental needs (in their own words):** |
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| **Details for the referral:** |
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| **Provisional or Definitive Diagnosis** |
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| **Briefly describe how the service requested fits in your overall treatment plan.** |
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| **Summary of medical history:** |
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| **Does this patient require support services such as a Social Worker?** | |
| No  Yes | If yes, please provide a brief overview of support services required: |

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| **Referring Clinician details:** | **Phone:** | **Clinical Supervisor** |
| Or completed on behalf of |  | Approval provided by: |
|  | | For Students: |

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| ***Community Dental Clinic referring:*** |  |
| ***Community Dental Clinic mailing address:*** |  |
| ***Referring Clinician email:*** |  |

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| **ORTHODONTIC REFERRAL CHECKLIST** | |
| **Description of the Malocclusion** | |
| Please provide as much detail as possible. If insufficient detail is provided, there may be a delay in the processing of the referral. | |
| **IOTN Grade 5 – Very High Treatment Need**  Overjet > 12mm  Reverse overjet > 4mm  Impeded eruption of teeth (except third molars) due to crowding, displacement, presence of supernumerary teeth, or retained deciduous teeth (These cases may not require appliances) | |
| **IOTN Grade 4 – High Treatment Need**  Overjet 9-12mm  Reverse overjet 2-4mm  Anterior crossbite > 1mm mandibular displacement  Posterior crossbite > 2mm mandibular displacement  Crowding > 10mm in one arch  Anterior or posterior open bite > 4mm  Rotation of anterior tooth > 30°  Increased, complete/overbite causing recession of upper lingual or lower labial gingivae  Patients with missing upper anterior teeth requiring pre-prosthetic orthodontics or orthodontic space closure to obviate the need for a prosthesis **may** also be accepted. | |
| **Occlusion and Measurement of Crowding** | |
| **Incisor relationship:**  Class 1  Class 2 div 1 overjet:       mm  *(Minimum value for treatment: 9mm)* | Class 2 div 2  Class 3 reverse overjet:       mm  *(Minimum value for treatment: -2mm)* |
| Overbite (vertical overlap):        mm | |
| Overbite causing gingival recession:  Yes  No       mm | |
| Openbite:         mm Anterior Posterior | |
| Teeth in crossbite: | |
| Mandibular deviation on closure (hit and slide):  No  Yes       mm  Please specify tooth/teeth: | |
| Midline discrepancy:  Maxilla  No  Yes  Mandible   No  Yes  Please specify in millimeters: | |

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| **Missing Teeth** |
| Please specify: |
| **Spacing:** |
| Amount:  Location: |
| **Displaced Teeth:** |
| Please specify: |
| Distance:       mm: *(minimum value for treatment: 4mm)* |
| Position: *(for example; Bucc / Ling)* |
| **Rotations > 30°** |
| Please specify: |
| **Impacted Teeth:** |
| Please specify: |
| **Additional Requirements:** |
| If the malocclusion cannot be clearly described, models and a wax bite are required.  Models and Wax bite sent by mail: |

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| **Oral Health** |
| An examination for caries has been completed with the last six months  Yes  No |
| All carious teeth have been restored (unless extractions are proposed).  Yes  No |
| The gingival tissues are in good health and oral hygiene is excellent  Yes  No |
| By submitting this referral I, on behalf of the referring clinic, agree to ensure regular recalls of the patient are provided, both while on the waiting list and throughout orthodontic treatment  Yes |