Strydom Orthodontics Inc

15 Kildare Road, Newlands, Cape Town, 7700
Tel: (021) 674 6560 Fax: (021) 683 2880
e-mail: info@strydomorthodontics.co.za website: www.strydomorthodontics.co.za

Orthodontic referral form

Date of referral _____

Referring dentist

Name _____

E-mail _____ Tel number _____

Patient details

Name _____ Date of birth_____

Address _____

E-mail _____ Tel number _____

Relevant medical history _____

Reason for referral

☐ Assessment and treatment ☐ Assessment only ☐ Early/mixed dentition assessment

Other reasons (please specify) _____

Patient's concerns (please tick all of the applicable boxes)

☐ Dental crowding/Ectopic eruption ☐ Dental Spacing ☐ Increased overjet

☐ Reversed overjet ☐ Deep bite ☐ Open bite

☐ Missing teeth ☐ Crossbite ☐ Facial esthetics

Other concerns (please specify) _____

Clinical situation (please tick all of the applicable boxes)

☐ Deciduous dentition ☐ Mixed dentition ☐ Permanent dentition

☐ Good oral hygiene ☐ Moderate oral hygiene ☐ Poor oral hygiene

☐ Good motivation ☐ Uncertain motivation ☐ Poor motivation

Relevant radiographs enclosed

☐ PAN ☐ Ceph ☐ Periapical ☐ Bitewings ☐ None taken

Special requests or remarks

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