# Dental Services Referral Form - Orthodontic Clinic

<table>
<thead>
<tr>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Title:</th>
<th>Surname</th>
<th>Given name</th>
<th>Date of birth:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Street address</th>
<th>Suburb</th>
<th>Postcode</th>
</tr>
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<tbody>
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</table>

Name of Residential Facility (if applicable)

Room:

<table>
<thead>
<tr>
<th>Phone -</th>
<th>Home:</th>
<th>Mobile:</th>
<th>Work:</th>
</tr>
</thead>
<tbody>
<tr>
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Country of birth:

<table>
<thead>
<tr>
<th>Needs interpreter:</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tr>
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</table>

Language:

Indigenous status:

- Neither Aboriginal nor Torres Strait Islander
- Aboriginal but not Torres Strait Islander
- Torres Strait Islander but not Aboriginal
- Both Aboriginal and Torres Strait Islander

Concession Card type:

- Pensioner Concession Card
- Health Care Card

Concession Card No: Expiry date:

For Under 18 patients:

Parent/Guardian name(s):

Relationship to patient: Phone:

School:

For patients unable to provide self-consent:

Person Responsible name:

Relationship to patient: Phone:

Address:

| Ability to attend appointments at short notice if available due to vacancies: |
|-----------------------------|----------------|-------------|
| Within 24 hours | Within 1 week | No, require more notice |

Once complete please return to:

Patient Services Centre
The Royal Dental Hospital of Melbourne
GPO Box 1273L
Melbourne 3001
Reason for referral:  
☐ Examination and treatment  
☐ Opinion only from information provided from examination of patient  
☐ Treatment urgency  
☐ Urgency 1: Suspected malignancy, trauma, medical priority, patients to be seen the same day  
☐ Urgency 2: Patient experiencing pain  
☐ Urgency 3: Patient not experiencing pain  

Are you referring this patient to more than one RDHM Clinic?  
☐ No  
☐ Yes – please specify the other RDHM clinic(s)  

Details for the referral:  

Patient’s / Person Responsible’s main concern / dental needs (in their own words):  

Briefly describe how the service requested fits in your overall treatment plan.  

Summary of medical history: (please attach patient’s current full history)  

<table>
<thead>
<tr>
<th>Notable issues</th>
<th>Summary information</th>
<th>Details attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical or sensory impairment</td>
<td>Sight</td>
<td>None known</td>
</tr>
<tr>
<td>Intellectual impairment</td>
<td>Learning</td>
<td>None known</td>
</tr>
<tr>
<td>Falls Risk / Pressure Ulcers</td>
<td>Falls Risk</td>
<td>None known</td>
</tr>
<tr>
<td>Medications</td>
<td>Prescribed</td>
<td>None known</td>
</tr>
<tr>
<td>Allergies / ADR</td>
<td>Allergy</td>
<td>None known</td>
</tr>
<tr>
<td>Other significant risks</td>
<td>Yes</td>
<td>None known</td>
</tr>
</tbody>
</table>
**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.

**Incisor relationship:**
- [ ] Class 1
- [ ] Class 2 div 1 overjet: mm
- (minimum value for treatment: 9mm)
- [ ] Class 2 div 2 overjet: mm
- [ ] Class 3 reverse overjet: mm
- (minimum value for treatment: -2mm)

**Additional requirement:**
If a skeletal problem may be contributing to the malocclusion, a lateral cephalogram is required.
- [ ] Lateral cephalogram sent by mail

**Overbite:** mm
**Overbite causing gingival recession:** [ ] Yes [ ] No
**Openbite:** mm

**Occlusion**

**Teeth in crossbite:**
- [ ] No
- [ ] Yes: mm

**Midline discrepancy**
- [ ] No
- [ ] Yes: Please specify

**Measurement of crowding**

**Maxillary Arch:** mm
- (minimum value for acceptance: 10mm)

**Mandibular Arch:** mm
- (minimum value for acceptance: 10mm)

**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

**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 (up to two years) and throughout orthodontic treatment [ ] Yes
### Requirements checklist

<table>
<thead>
<tr>
<th>Additional information required; please tick applicable options for each requirement</th>
<th>Current OPG (all cases) less than 12 months old</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ sent</td>
</tr>
<tr>
<td></td>
<td>Lateral Cephalometric in cases where there may be a skeletal discrepancy (class 2, class 3, deep overbite, open bite).</td>
</tr>
<tr>
<td></td>
<td>☐ sent</td>
</tr>
<tr>
<td></td>
<td>Study models if the malocclusion is complex. Include an occlusal registration or mark the occlusion on the models</td>
</tr>
<tr>
<td></td>
<td>☐ sent ☐ N/A (not necessary in this case)</td>
</tr>
<tr>
<td></td>
<td>● Ensure the models can occlude by removing excess plaster from the distal before it sets</td>
</tr>
<tr>
<td></td>
<td>● Ensure the model is completely air-dry (at least 24 hours) before packaging and sending to RDHM, to prevent mould growth on the model</td>
</tr>
<tr>
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<td>● Ensure the model is packaged to protect it from damage during shipping, e.g. Bubble Wrap®, or packed securely in carry boxes</td>
</tr>
<tr>
<td></td>
<td>● Ensure each model is labelled correctly with the patient details, and on the outside of the packaging</td>
</tr>
</tbody>
</table>

### Accurate and current medical history

|  |☐ sent |

For adult patients – A periodontal assessment with recording of pocket depths, plaque index, recession and any bone loss

|  |☐ sent |

Measurements of all features of the malocclusion and a full description of any features not specifically requested on the referral forms. See section above.

|  |☐ completed |

### Screening clinician’s notes (RDHM use):

<table>
<thead>
<tr>
<th>Referring Clinician details:</th>
<th>Phone:</th>
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<tr>
<td>☐ Or completed on behalf of</td>
<td></td>
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</table>

Please record provider type

- ☐ Dentist
- ☐ Oral Health Therapist
- ☐ Dental Therapist
- ☐ Dental Hygienist
- ☐ Other

Clinic mailing address: |
### Appropriate patients
- The general dental care of the patient should have been completed
- Patient has excellent oral hygiene to be considered for an appliance
- The family has been informed of this requirement by the referring clinician.

### Screening consultation
- Acceptance to the Orthodontic Clinic for comprehensive care is subject to a screening consultation.

### Clinical criteria

#### The Index of Treatment Need is a guide for the screening process in this clinic with the final decision made by the head of unit.

#### Orthodontic treatment priority index for treatment need

Only patients in Grade 4 or 5 treatment priority categories will be considered for treatment.

- **Grade 5 – Very Great Priority**
  - 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)

- **Grade 4 – Great Priority**
  - 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

- Missing upper anterior teeth requiring pre-prosthetic orthodontics or orthodontic space closure to obviate the need for a prosthesis
- Patients must be available to attend The Royal Dental Hospital of Melbourne for multiple visits, often over many years
- For adult patients there must also be a major improvement in oral health anticipated as a result of treatment. Very few adults are accepted
- Patients who have had periodontal disease are only treated in the maintenance phase

### Exclusions
- The majority of patients with malocclusions cannot be accepted (patients & parents should be made aware of this)
- Patients with cleft defects of lip and/or palate are covered by the Medicare Cleft Palate Scheme and can attend a private orthodontist or The Royal Children’s Hospital
- Gingival bleeding on probing
- Plaque index > 20%

### Patients who do not meet the clinical criteria
- Can be referred for an opinion if the referring dentist believes that extraction of teeth may be indicated.
- Patients with temporomandibular disorders who do not meet the Grade 4 or 5 criteria for orthodontic referral should be referred to the Facial Pain and TMD Clinic.

### On going care required by referring clinician.
- By submitting this referral, I on behalf of the referring clinic, acknowledge that the referring clinic is responsible for overall general care to this patient both while on the waiting list and throughout treatment at RDHM

[Click here to return to top - click]