UTHSC ORTHODONTIC REFERRAL FORM

Date: ____________________ Referring Office: ____

Dentist/Hygienist/Staff Name: ____

Patient Name: ______________________________ __________ _____________________________________

FIRST MIDDLE LAST

Date of Birth: ____________________ Parent/Guardian Name: ______________________________________

Cell Phone Number: ________________________ Alternate Phone Number: ___________________________

Email: ____

Insurance Provider: _________________________________ TennCare: _______________________________

Last Cleaning: __________________________________ X-rays available: ______________________________

This patient is being referred for:

- ☐ General Orthodontic Evaluation
- ☐ Facial Growth Disorder
- ☐ Early Interceptive Treatment
- ☐ Clear Aligner Consultation
- ☐ Pro-prosthetic/Pre-Implant Treatment
- ☐ TMJ Disorder Evaluation
- ☐ Habit Correction
- ☐ Minor Tooth Movement
- ☐ Other _________________________

Clinical findings:

- ☐ Airway/Breathing Concerns
- ☐ Missing Teeth
- ☐ Class II
- ☐ Open Bite
- ☐ Class III
- ☐ Crossbite/Functional Shift
- ☐ Growth/Skeletal Imbalance
- ☐ Facial Esthetics
- ☐ Other ____________________
- ☐ Overbite
- ☐ Overjet
- ☐ Crowding
- ☐ Spacing
- ☐ Space Maintenance
- ☐ Impacted Teeth
- ☐ Speech Concerns
- ☐ Ectopic Eruption

Remarks: ____

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COLLEGE OF DENTISTRY

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