UTHSC ORTHODONTIC REFERRAL AND CLEARANCE FORM

Please send any recent x-rays, especially a pano (if taken), along with this completed form to cbuckle5@uthsc.edu.

When this form has been received, your patient will be contacted for their orthodontic screening. If the patient has TennCare, the documentation will be sent to obtain approval/denial of treatment. Thanks in advance for your courtesy and promptness in completing this form.

Patient name: _____ _____ _____
FIRST MIDDLE LAST

Date of birth: _____/_____/_____ Parent/guardian name: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Insurance Provider: _____ TennCare ID: _____

Referring Office: _____ Phone: _____

1. Is the patient seen at your office for routine dental care? ☐ Yes ☐ No
2. Date of last cleaning (must be within 6 months): _____/_____/_____
3. Date of patient's last visit to your office: _____/_____/_____
4. Was the patient caries free as of the last visit? ☐ Yes ☐ No
5. Does the patient exhibit competency in maintaining oral hygiene? ☐ Yes ☐ No
6. Has all restorative work been completed and is patient cleared for orthodontic treatment? ☐ Yes ☐ No

This patient is being referred for:

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

Clinical Findings:

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

Additional comments regarding patient's oral hygiene pertaining to potential orthodontic treatment?

_____

_____ _____ _____/_____/_____
Dentist's Name Dentist's Signature Date

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