

Any other relevant details:

I am willing to provide NHS treatment for this patient, following recommendations from a Consultant Orthodontist. Please tick:

Removable Appliances

Fixed Appliances

Functional Appliances

Dentist/Practitioner Signature **Date**

SECTION TWO: TO BE COMPLETED BY THE RECEPTIONIST / PATIENT/ PARENT / LEGAL GUARDIAN

Please use block capitals

Patient's Last Name:

Sex

Male

Female

First Name:

Address:

.....

Postcode: Telephone Number

Date of Birth/...../..... School (if applicable)

Name and Address of parent/guardian (if different from above)

.....

Do any other members of the family attend the department

Yes/ No

If yes, please state name(s) and date(s) of birth

Name & address of General Medical Practitioner (GP)

Please return to the Orthodontic Department, Box 47, Addenbrooke's NHS Trust, Hills Road, Cambridge. CB2 2QQ

Telephone: 01223 216 412 Fax:01223 216 708