WINDMILL
ORTHODONTICS

Referrals to Windmill Orthodontics

At Windmill Orthodontics we prefer to work as closely as possible with referring dentists, building partnerships that deliver true excellence in patient treatment and care.

You can refer patients to Windmill Orthodontics in a number of different ways.

On-line:

We offer secure on-line referral (www.windmillorthodontics.com) via which you can upload your patient's information and images (ie photographs and X-rays). Once you have registered on our website with your login and secure password, as well as referring, you will be able to share your patient's images, correspondence and notes from us.

Email:

You can email us using either the proforma overleaf (also available to download on our website) or by personal correspondence.

referral@windmillorthodontics.com

Telephone:

Call our receptionist on 0844 387 2000.

Post:

You can refer to us by post using either the proforma overleaf (also available to download on our website) or by personal correspondence.

Bedale

Alpha Dental
Mawson House
Bedale
DL8 1AW

Carlisle

The Sidings
Port Road
Carlisle
CA2 7AF

Gateshead

InDental
2a Fewster Square
Gateshead
NE10 8XQ

Newcastle

37 Heaton Rd
Newcastle upon Tyne
NE6 1SB

Penrith

Ghyllmount Dental
4 Hobson Court
Penrith 40 Business Park
Penrith
CA11 9GQ

York

Alpha Dental
1a Almsford House
Beckfield Lane
Acomb
York
Y026 5PN

Contact phone number: *(for all practices)* 0844 387 2000 **Contact email:** *(for all practices)* reception@windmillorthodontics.com

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Orthodontic Referral to Specialist Practice

Please ensure that all referrals contain at least the following information

Practice Referring To

Bedale / Carlisle / Gateshead / Penrith / York / Newcastle

Referring Details

Name:

Address:

Postcode:

Telephone:

Email:

Fax:

Patient Details

Name:

Date of Birth:

Address:

Postcode:

Telephone: Home:

Work:

Mobile:

Email:

Name of parent/guardian:

Relevant Medical History

General Assessment of Dental Health

Dental History

Attendance: Regular / infrequent / first visit

Co-operation

Patient motivation

Oral Hygiene: Poor / fair / good

IOTN **DH** _ 3 / 4 / 5 _ **AC** _____

Reason for Referral

Patient's concern/complaint:

My dentist has explained why I /my son /daughter has been included referred for an orthodontic assessment. I understand what is involved and am interested in supporting them in having any necessary orthodontic care.

Patient's / parent's signature:

Date:

Radiographs included Y / N

Which radiographs are included:

Previous orthodontic referral Y / N

If Yes:

Salaried service Y / N

Specialist practitioner Y / N

Non-specialist practitioner Y / N

Hospital Y / N

Signed:

Date: