NI HEALTH AND SOCIAL SERVICES (BSO)
ORTHODONTIC DIAGNOSIS : NON-APPLIANCE CASES

Please complete or tick boxes as appropriate

Patient's Name.....

Date of Birth .....

Referred by.....

Date of Examination.....

Dental Health Component of IOTN ☐

Aesthetic Component of IOTN ☐

Dentist's Name and Code Number ☐

A. DEVELOPMENTAL STATE

1. Erupted dentition

2. Unerupted dentition

3. Radiographs taken:

Justification

Report

Pathology to be reported to ODS Yes ☐ No ☐ If Yes, please give detail

A copy of the relevant radiographs(s) is to be forwarded to ODS Yes ☐ No ☐

B. ASSESSMENT

1. Skeletal classification

I ☐
II ☐
III ☐

2. Soft tissue morphology - lip and tongue posture/behaviour

Normal Yes ☐

No ☐

3. Incisor relationship

		(a) Overbite:		(b) Overjet in millimetres	(c) Centre line
I	☐	Normal		☐	
II DIV I	☐	Increased	: complete	☐	
II DIV II	☐		: incomplete	☐	
III	☐	Decreased		☐	

4. Buccal occlusion and path of closure

(a) Antero-posterior

Molar relationship: I		
Molar relationship: II		
Molar relationship: III		

(b) Bucco-lingual

Crossbite:	None	
	Left	
	Right	

(c) Lateral deviation

None	
Left	
Right	

5. Tooth/bone relationship:

	Normal	Spaced	Crowded
Upper arch			
Lower arch			

6. Relevant habits:

Yes ☐

Please specify _____

No ☐

None Relevant ☐

7. General comments:

(a) Please comment on state of dental health and oral hygiene

(b) Please comment on condition of first permanent molars

8. Other relevant medical or dental information e.g. heavily restored/carious teeth

Yes ☐ No ☐

C TREATMENT PLAN

D RECORDS

Study models taken and forwarded to the agency ☐

SIGNATURE OF EXAMINING DENTIST: _____

DATE: _____