Dentist Referral Form

DOS Donated Orthodontic Services | AAOF American Association of Orthodontists Foundation

Dentist: Your patient has applied to receive Donated Orthodontic Services. Please complete the referral form on their behalf. Donated Orthodontic Services is a program of the American Association of Orthodontists Foundation (AAOF), with a goal of providing orthodontic treatment to children whose need is significant enough to suffer detrimental dental and/or social effects. Thank you for taking the time to thoughtfully consider your response.

Completed forms may be returned via secure fax to 314.689.0293.

Patient Name:	**DOB:**
How long has the patient been under your care?	
How often are they seen?	
Is the patient in <u>need</u> of orthodontic treatment? ☐ Yes ☐ No	
Is the patient motivated to receive orthodontic treatment? ☐ Yes ☐ No	
Does the patient's family keep appointments? ☐ Yes ☐ No	
Is the patient carries free? ☐ Yes ☐ No	
Does the patient have good oral hygiene? ☐ Yes ☐ No	

Description of patient's current condition:

Dentition	☐ Primary	☐ Mixed	☐ Permanent
Malocclusion	☐ Not Severe	☐ Moderate	☐ Severe
Spacing	☐ Yes ☐ No	Comments:	
Crowding	☐ Yes ☐ No	Comments:	
Overjet	☐ Yes ☐ No	Comments:	
Crossbite	☐ Yes ☐ No	Comments:	
Overbite	☐ Yes ☐ No	Comments:	
Misalignment	☐ Yes ☐ No	Comments:	

Would you recommend this patient for treatment through the DOS program? ☐ Yes ☐ No

Please include anything else that should be considered when evaluating this case:

Dentist Signature:	Office Contact Information:
Dentist Name (please print):	Date:

Thank you for your assistance! Questions: 1.800.424.2841 x582