Donated Orthodontic Services (DOS)

1800 15th Street, Suite 100 • Denver, Colorado 80202 • 866.201.5906 phone • 303.534.5290 fax

Dear Dentist:

Please complete the following orthodontic referral for the Donated Orthodontic Services (DOS) program.

Date: ________________ Dentist Name: ____________________________________

Dentist Phone Number: ______________________________

Patient Name: ____ Date of Birth: ____________

Date of Last Appointment: ___________________

How often are they seen in your office: ________________________

Is Patient in need of orthodontic treatment? ____Y ____N

Description of current condition:

Malocclusion:

o Class I	o Class II	o Class III

Spacing:

o Mild ≤ 3mm	o Moderate 4-6mm	o Severe ≥ 7mm

Crowding:

o Mild ≤ 3mm	o Moderate 4-6mm	o Severe ≥ 7mm

Overjet:

o Normal	o Moderate 2-5mm	o Severe ≥ 6mm

Crossbite:

o None	o Anterior	o Posterior

Overbite:

o Normal	o Moderate (50-75%)	o Severe > 75%	o Open Bite

Misalignment:

o None	o Mild	o Moderate	o Severe

Description of Dentition: ________ Primary _________ Mixed ________ Permanent

Does Patient have good oral hygiene? _____ Y ____ N

Caries free? ____Y ______ N

Does the family keep appointments? _____ Y ______ N

Is the child motivated to receive orthodontic treatment? ______________________________

Comments:

Signature:________________________