Wish For A Smile Dental Assessment Form

TO BE FILLED IN BY THE APPLICANT'S DENTIST OR DENTAL THERAPIST

(not a specialist orthodontist)

Patient's First Name	**Surname**	**DOB: dd/mm/yyyy**	**Age:**
Address:			
Suburb:	**Region:**		**Post Code:**
Home Phone:	**Mobile Phone:**		

GENERAL INFORMATION

Your patient wishes to apply to the NZAO Wish For A Smile Trust for the provision of orthodontic treatment by a specialist orthodontist.

Thank you for completing this form. Please ensure this completed, signed form is given back to the applicant who will submit it as part of their application process.

Alternatively you may complete it online at **www.wishforasmile.org.nz**

The Wish For A Smile Trust uses the Dental Health Component of the Index of Orthodontic Treatment Need (IOTN), as a basic assessment tool recording various occlusal traits that are likely to increase the morbidity of the dentition and surrounding structures. Practical implementation calls for a "good sense of judgment" by the referring dental practitioner/therapist.

Your patient must be aged 11 – 16 years and present with **at least TWO or more of the following occlusal traits** to be able to apply to the Wish for a Smile Trust. A photo guide of these traits is provided for your use. Please provide as much detail as you can and attach any additional information you feel will help the Trust assess your patient's application.

Applications with only **ONE occlusal trait will NOT BE ACCEPTED.**

DENTAL ASSESSMENT

1. **Has the eruption of permanent teeth been delayed?** – this includes impaction of teeth (but NOT 3rd molars). Please provide information on the presence of supernumeraries or pathology.

   Yes ○ **No** ○

   Additional Information:

   _____

2. **Are there FOUR or more missing teeth?** – (do not include 3rd molars)

   Yes ○ **No** ○

   Additional Information:

   _____

3. **Is there an increased overjet of 7mm or more** on any anterior tooth?

   Yes ○ **No** ○

   Additional Information:

   _____

4. **Is there a reverse overjet of 3mm or more** on any anterior tooth?

   Yes ○ **No** ○

   Additional Information:

   _____

5. **Is there significant crowding? –** there must be a displaced contact between any two adjacent teeth of 5mm or greater

   Yes ○ **No** ○

   Additional Information:

   _____

6. **Is there an anterior open bite of 4mm or more (**the open bite MUST NOT be associated with any digit/cloth sucking habit)

   Yes ○ **No** ○

   Additional Information:

   _____

7. **Is there trauma to the gingiva or palatal mucosa due to a deep overbite?**

   Yes ○ **No** ○

   Additional Information:

   _____

8. **Do you have any additional clinical findings?**

   Yes ○ **No** ○

   Additional Information:

   _____

GENERAL DENTAL HEALTH

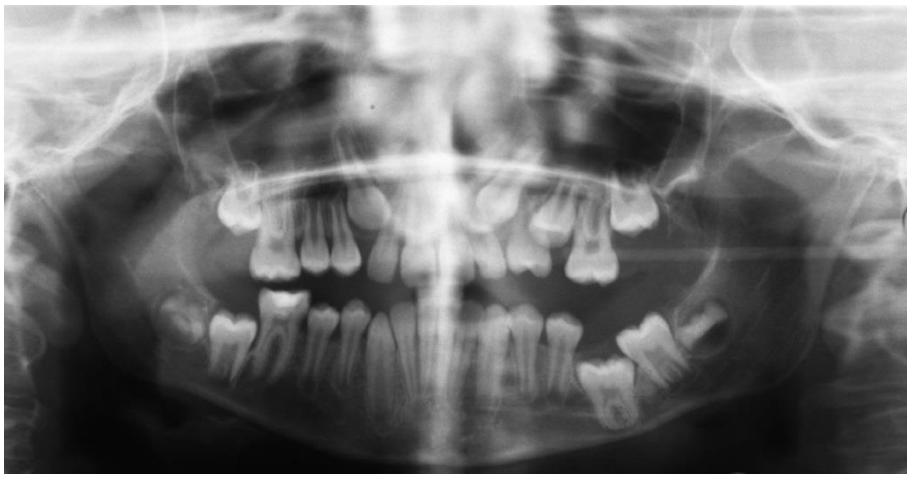
Oral Hygiene: Consistently Good ○ Acceptable ○ Fair ○ Poor ○ Additional Information**:**	
Caries control: Treatment Required: Yes ○ No ○ Additional Information:	
Trauma: Past History of Trauma: Yes ○ No ○ Details: Date and ACC Number if available:	
Dental Attendance: First Visit ○; 6 monthly ○; 12 monthly ○; 18 monthly ○; 2+ years ○ **Date of Previous Visit:**	
Name:	**Dentist** ○ **Therapist** ○ **Hygienist** ○
Address:	
	Post Code:
Contact Phone Number(s):	
Email:	
○ **I support this application to the Wish For A Smile Trust and confirm that the patient reaches the minimum severity threshold for at least TWO of the required orthodontic problems.** **Please sign and date:**	

Thank you for completing this form.

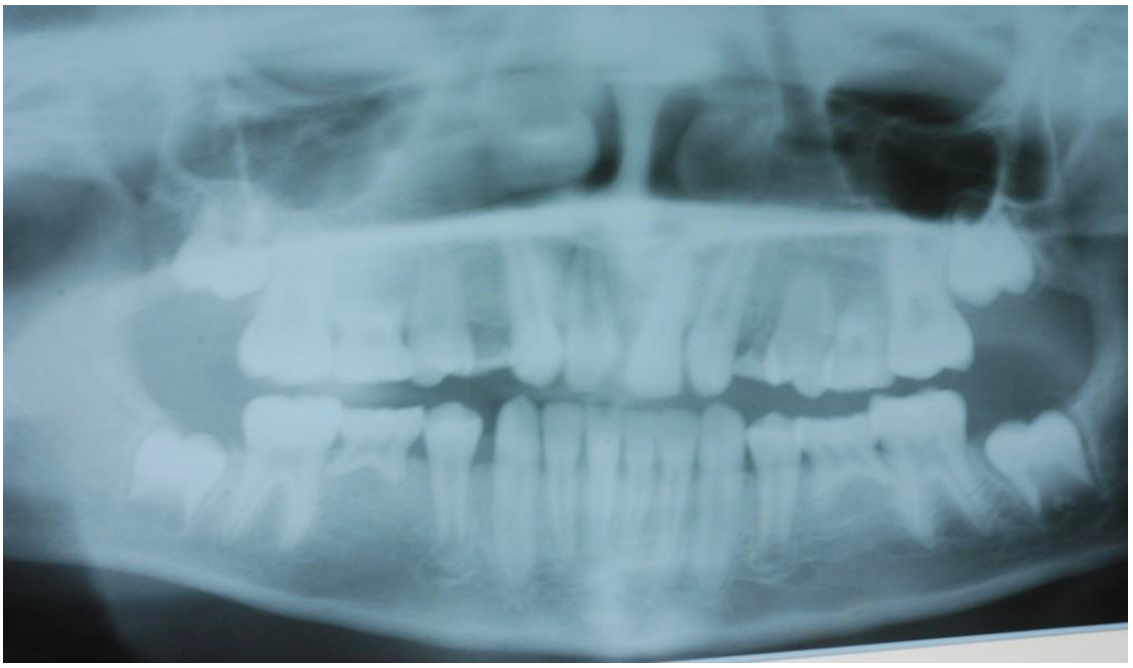
Please ensure this completed, signed form is given to the patient who will submit it as part of their application process.

Guide for completing the Wish For A Smile Dental Assessment Form

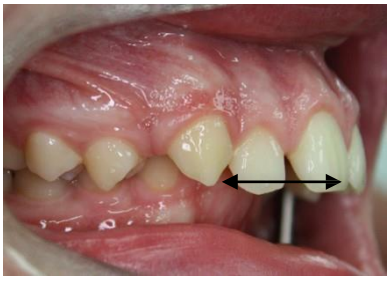
Question 1: Delayed eruption of teeth including supernumeraries, pathology and impacted teeth (but NOT 3rd molars).



Question 2: Missing teeth (**FOUR or more**) not including 3rd molars (example missing 15,12,22,25,35,45)

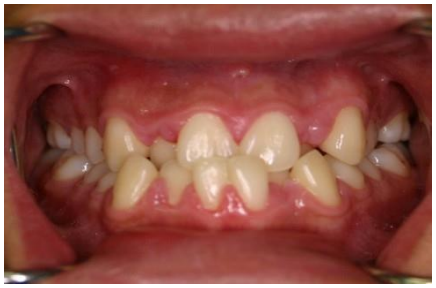


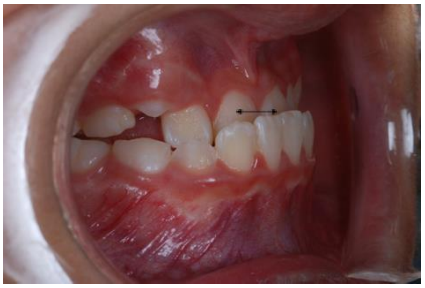
Question 3: Increased overjet of **at least 7mm** distance between the labial of the upper and lower incisors (example 10 mm overjet)



Must be at least a 7mm horizontal gap

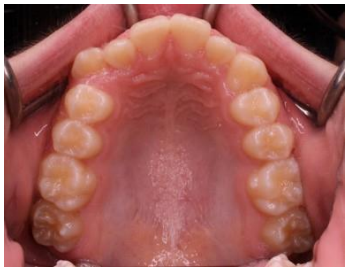
Question 4: Reverse overjet of **at least –ve 3mm** distance between the upper and lower incisors in crossbite (example –ve 3mm overjet)

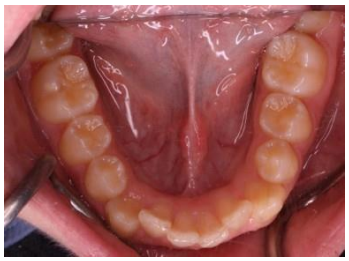




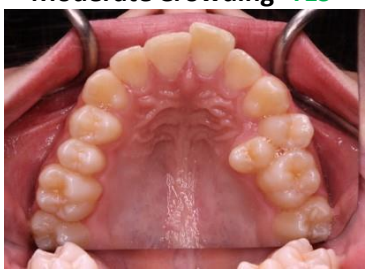
Question 5: Crowding with displaced contact points of **5mm or greater**

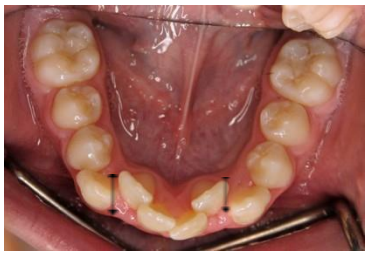
Mild Crowding <5mm – **NO**



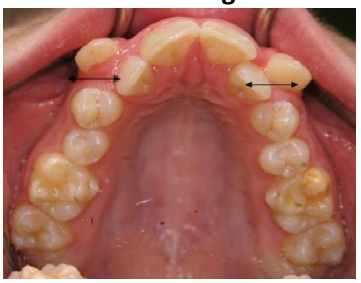


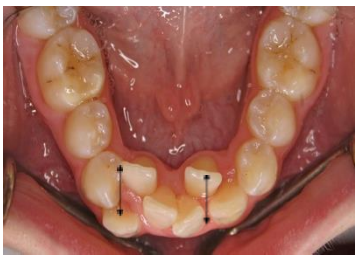
Moderate Crowding- YES



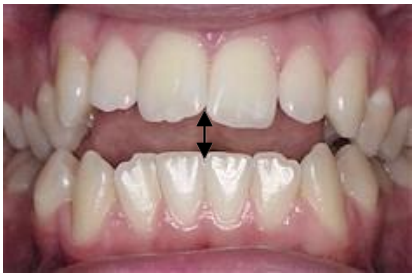


Severe Crowding - YES





Question 6: Anterior open bite of **4mm <u>vertical</u> gap** or more between the upper and lower incisors that is not associated with a digit sucking habit (example 4mm anterior open bite)



4mm vertical gap

Question 7: Trauma to the palate or lower labial gingival from a deep bite