American Association of Orthodontists

AAO Donated Orthodontic Services Program

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: _____

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

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: _____