

T-19 Dental Clearance for Orthodontic Consult

Name of Patient: _____

Name of Dentist: _____

(Note: Clearance by the dentist for an orthodontic consult is not a guarantee that the patient will qualify for State funded orthodontic treatment)

Patient must meet all the following criteria. (Please check all that apply)

- _____ Patient is 12-18 years old.
- _____ Patient has good oral hygiene.
- _____ Patient has all dental restorations completed.

To be considered by the State for funding for orthodontic treatment, the patient must meet at least **ONE** of the following criteria.

- _____ Cleft lip/cleft palate
- _____ Impacted anterior tooth/teeth
- _____ Deep impinging overbite with evidence of tissue damage on the palate
- _____ Anterior crossbite causing tissue destruction
- _____ At least 30 total points on the HDL scale.

HDL scale	Score
Severe bite problem documented by speech therapist or physician (15 pts)	
Overjet in mm (1 pt per mm)	
Overbite in mm (1 pt per mm)	
Class III molars (5 pts per mm of mandibular protrusion)	
Open bite (4 pts per mm of open bite)	
Ectopic eruption (3 pts per tooth erupted ectopically)	
Anterior crowding (5 pts per arch for a max of 10 points)	
Posterior crossbite (4 pts)	
TOTAL SCORE=	

Dentist's Signature: _____ Date: _____