Orthodontic Case Assessment

OCA 0415 NHS

PLEASE COMPLETE **ALL SECTIONS** IN BLACK INK

Performer Name:	Performer Number:

Patient's Details (in CAPITALS)

First name: Surname:

Provider's Name, Address and Location Number

Age of patient at **start of treatment**: ☐

Pre-treatment IOTN score: DHC grade (1 to 5) ☐ DHC qualifier (a to x) ☐ AC grade (1 to 10) ☐

Assessment

Extra-oral (Please tick the appropriate boxes)

Skeletal classification Class I ☐ Class II ☐ Class III ☐

FM angle High ☐ Average ☐ Low ☐

Transverse asymmetry? Yes ☐ No ☐ TMJ symptoms / click? Yes ☐ No ☐

Lips: Competent? Yes ☐ No ☐ Digit sucking habit? Yes ☐ No ☐

Intra-oral (Please tick the appropriate boxes)

Teeth present: ______________/________________ Teeth absent: _________/_________

Oral hygiene: Good ☐ Average ☐ Poor ☐ Erosion / decalcification evident? Yes ☐ No ☐

Caries evident: ____________/________________ Teeth of doubtful prognosis: ___________/____________

Occlusion (Please tick the appropriate boxes)

Incisor relationship: Class I ☐ Class II/1 ☐ Class II/2 ☐ Class III ☐

Overjet ……….mm Edge to edge ☐ Reverse ………mm

Overbite Increased ☐ Average ☐ Decreased ☐ Complete ☐ Incomplete ☐ Anterior open bite……....mm

Centre lines ________/_________ (show shift by arrows) Anterior cross-bites: ______/________

Buccal occlusion: Right: Class I ☐ Class II: ¼ unit ☐ ½ unit ☐ ¾ unit ☐ full unit ☐ Class III ☐

Left: Class I ☐ Class II: ¼ unit ☐ ½ unit ☐ ¾ unit ☐ full unit ☐ Class III ☐

Posterior cross-bites: ______/______Associated mandibular displacement (mm): Right……..Left…… Anterior……….

Radiographs:

Number obtained: Panoramic ………….. Lateral cephalometric……….. Intra-oral……………

Teeth absent: ________/_________ Pathology evident: Yes ☐ No ☐ Details …………………………

Cephalometric analysis: SNA ……….° SNB…..…..° MMPA ……..° UI- MxP…….…° LI-MdP ………°LI-APo ……….mm

Treatment

Was an FP17 DCO given to the patient? Yes ☐ (please attach a copy) No ☐

Aims of Treatment: (Please tick the appropriate boxes)

Relief of crowding ☐ Maxillary arch-expansion ☐ Alignment ☐ Levelling ☐ Arch-co-ordination ☐ Space closure ☐

Correction of incisor relationship ☐ Correction of buccal segment occlusion: antero-posteriorly ☐ laterally ☐

Extractions: ________/__________
/

Appliances Provided:

Type of appliance	Date fitted	Date withdrawn / removed
Removable appliance **Upper:** **Lower:**		
Functional appliance		
Upper fixed appliance		
Lower fixed appliance		
Removable retainers **Upper:** **Lower:**		
Fixed retainers **Upper:** **Lower:**		

Retention regime (months): Full time…….. Part-time……..Nocturnal…….. Duration of supervised retention………...

Has the course of treatment been successfully completed? Yes ☐ **No** ☐ (please tick appropriate box).

If 'No' was treatment abandoned ☐ **discontinued** ☐ **or still on-going** ☐ (please tick appropriate box).

Are you satisfied with the result? Yes ☐ **No** ☐ **N/A** ☐ (please tick appropriate box).

If 'No' why not?

Are there any missing records? (Please specify)

Any other relevant information you wish to be taken into consideration? (e.g. treatment of intentionally limited objectives or poor patient co-operation). Please use a separate sheet if necessary.

Performer's signature…………………………………………………………… Date ……/……./…….