

REFERRAL FORM

This form must be completed in full or treatment of the patient may be delayed.

ALL INFORMATION IS STRICTLY CONFIDENTIAL AND WILL BE HELD BY THE AREA HEALTH SERVICE.

Referral Centre: (please select)

Westmead Centre for Oral Health

Sydney Dental Hospital : Other Centre (enter name)

PATIENT DETAILS:
TITLE SURNAME

Interpreter Required: YES / NO
GIVEN NAME

MEDICARE NUMBER

HEALTH CARD NO

ADDRESS

DOB

POST CODE

HOME TEL

COUNTRY OF BIRTH

MOBILE

FIRST LANGUAGE SPOKEN

BUS TEL

GENERAL MEDICAL PRACTITIONER NAME:		CONTACT TEL:	
MEDICAL SPECIALIST NAME:		CONTACT TEL:	

Referred to:	Enclosures	Dental Documents: Yes <input type="checkbox"/> No <input type="checkbox"/>
		Dental X-rays: Yes <input type="checkbox"/> No <input type="checkbox"/>
		Medical Documents: Yes <input type="checkbox"/> No <input type="checkbox"/>
		Specialists Reports: Yes <input type="checkbox"/> No <input type="checkbox"/>

Specialty:

History and Reason for referral:

Significant Medical History: (include any relevant access issues or special requirements)

(Signature) (Printed Name) (Date)

REFERRING CLINICIAN:

Provider Name: _____ Provider No: _____

Address: _____

Telephone: _____ Fax: _____ Email: _____