

FAMILY NAME

MRN

GIVEN NAME

MALE FEMALE

Facility:

D.O.B. ____/____/____

M.O.

ADDRESS

ORAL HEALTH SPECIALIST REFERRAL FORM

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Indicate referral centre (✓)

Dental Unit, Westmead Children's Hospital

Sydney Dental Hospital

Westmead Centre for Oral Health

Other _____

Postal Address

Cnr Hawkesbury Rd & Hainsworth St Westmead NSW 2145

2 Chalmers St Surry Hills NSW 2010

PO BOX 533 Wentworthville NSW 2145

Type of Specialist Service Required:

Patient Information:

Home number:

Mobile:

Work number:

Language spoken at home:

Country of Birth:

Interpreter required Yes No

Aboriginal Liaison Officer required Yes No

Medicare Number:

(please provide all 11 numbers)

Concession card

Pensioner Card number

Health Care Card number

Expiry date:

Referring Practitioner

Medical

Dental

Other

Type:

General

Specialist

Speciality _____

Name:

Address:

Telephone:

Fax:

Email:

Patient's Medical and Dental Information

1. Significant medical history: (include any relevant access issues / special requirements / guardianship)

2. Reason for referral and treatment history: (please ✓ the relevant box below to identify your request)

I request: an opinion opinion and management by a specialist general care (student only)

3. Provisional treatment plan:

4. Enclosures (please identify type e.g. radiograph, reports)

- _____
- _____
- _____

Office Use Only: Clinic/Dept: _____ Waiting List _____
Date entered: _____ Signed: _____



Holes punched as per AS2828-1999
BINDING MARGIN - NO WRITING