Facility:

ORAL HEALTH FEE FOR SERVICE SCHEME TREATMENT REFERRAL

Date: __________________________

Voucher type:  
- Place circle
  - Episodic
  - General
  - Denture

Presenting Condition

Provisional Treatment Plan

1 ____________________________ Radiographs supplied:  
   - Place circle
   - PA
   - BW
   - OPG

2 ____________________________ Tooth number ____________________________

3 ____________________________

4 ____________________________

Comments:

I hereby agree that the information provided is true and correct

Clinician’s Name: ____________________________ Signature: ____________________________ Date: __________

Patient’s Name: ____________________________ Signature: ____________________________ Date: __________

Clinic of issue: ____________________________

Please indicate name and contact details

Please ensure OPG is returned to the Clinic

NB: The private provider is to review and to be satisfied with the medical history, medications, treatment plan and obtain patient consent prior to the patient’s dental treatment.