

FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

ORAL HEALTH TREATMENT REFERRAL FORM

NB: If this referral form is incomplete or has not been completed correctly, do not commence procedure until treatment plan has been confirmed directly with the referring clinician.

Referring Clinician Details

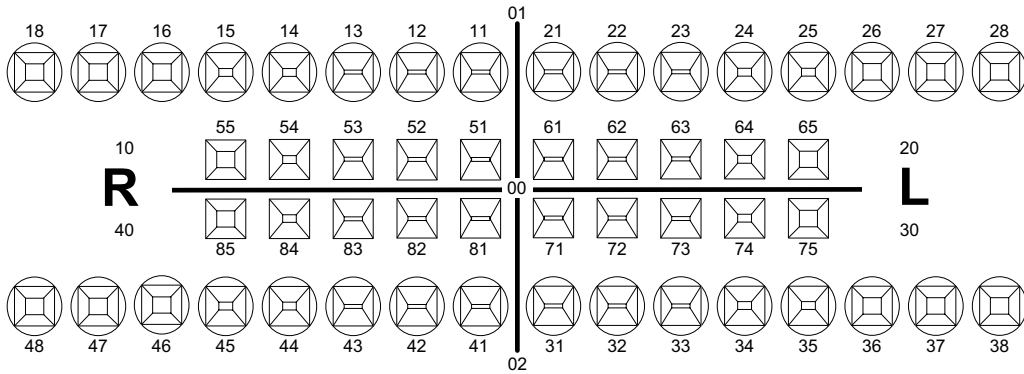
Name:
Organisation:
Address:
Phone No.:

Patient Information

Phone No.:
Medicare Card No.: _____
Position on card: ____
Pension Card No.: _____
HCC No.: _____
Expiry Date:
Interpreter required: Aboriginal Health Worker:

Referral MUST include charting of the treatment required on the odontogram, treatment plan in clear, legible English with Fédération Dentaire Internationale (FDI) notation, indication of radiographs supplied, reason for the referral and other patient information that is applicable.

Treatment Required



Treatment plan

- _____
- _____
- _____
- _____

Radiographs supplied: Yes / No
PA Tooth number _____
BW L R L&R
OPG

Reason for referral, significant medical history and further comments

NB: The referring clinician is to ensure that the charting and treatment plan is accurate and current x-ray/s are provided if an extraction is required.

I hereby agree that the information provided is true and correct

Referring Clinician Name: _____ Signature: _____ Date: _____



Holes Punched as per AS2828.1: 2012
BINDING MARGIN - NO WRITING

ORAL HEALTH TREATMENT REFERRAL FORM
SMR010.743