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
1. ___________________________________________________________
2. ___________________________________________________________
3. ___________________________________________________________
4. ___________________________________________________________

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: ____________