

REFERRAL FORM

Referring Practitioner	Patient
Doctor: _____	Name: _____
Tel: _____	Date of birth: _____
Address: _____	Tel: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
_____	Address: _____
_____	_____

Purpose of Referral

Consultation and treatment Others: _____

Second orthodontic opinion _____

Consultation only (possible treatment by general practitioner) _____

Assessment for interdisciplinary treatment _____


Main Concern:

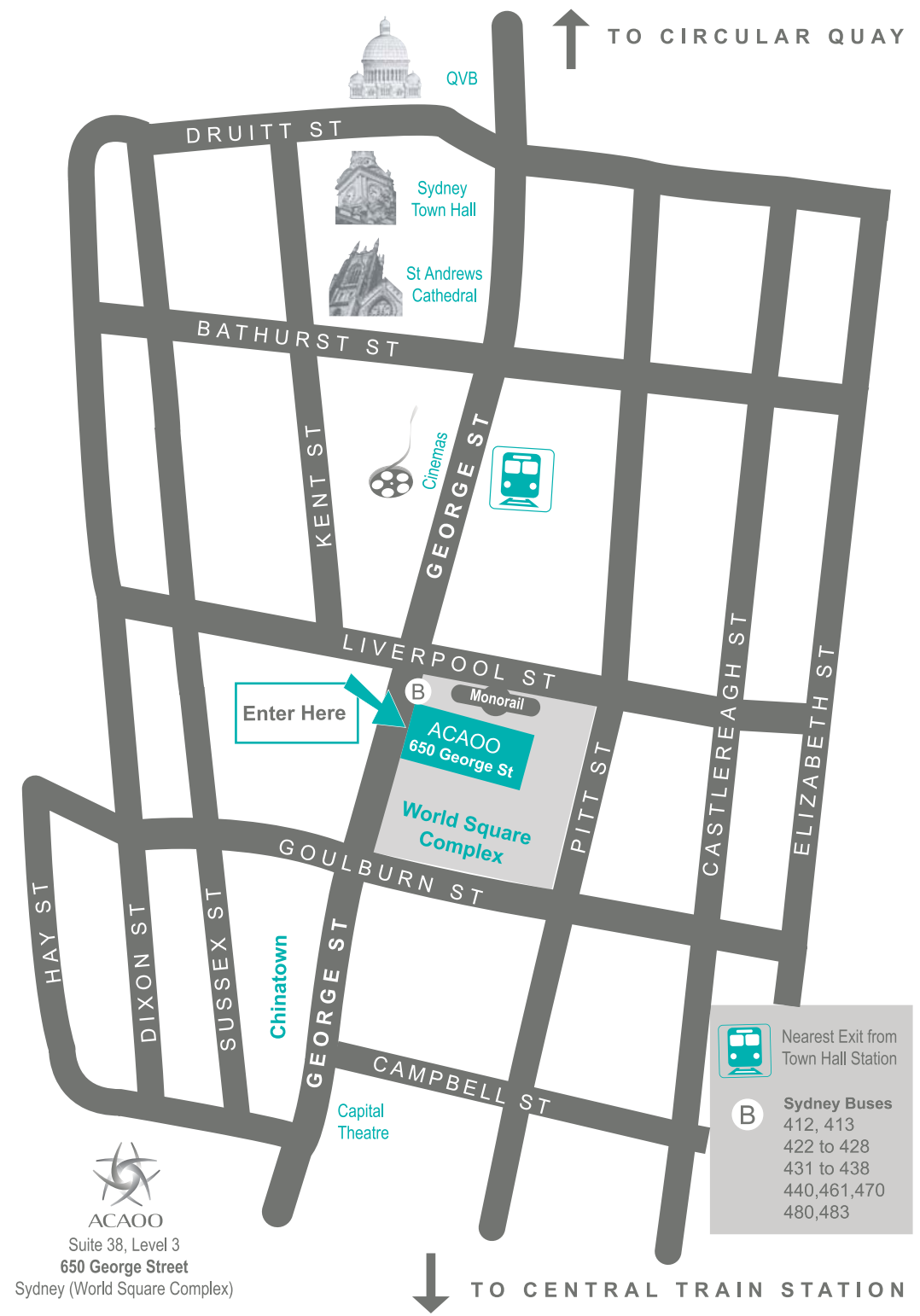
Dental Status	Relevant Medical History
Caries Risk <input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low	<input type="checkbox"/> Nil <input type="checkbox"/> Yes
Oral Hygiene <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Teeth with Questionable/Poor Prognosis: _____	
<input type="checkbox"/> Patient is dentally fit for orthodontic treatment.	
<input type="checkbox"/> Radiographs enclosed <input type="checkbox"/> OPG <input type="checkbox"/> Lat. Ceph. <input type="checkbox"/> Others	

Comments:

Signature: _____ **Date:** _____

Patient: Please bring this referral letter with you to your consultation.

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ACAEO
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