The Australian Centre for Adult Orthodontics and Orthopaedics

REFERRAL FORM

Referring Practitioner	Patient
Doctor: _____	Name: _____
Tel: _____	Date of birth: _____
Address: _____	Tel: _____ Sex: ☐ M ☐ F
_____	Address: _____
_____	_____

Purpose of Referral

- ☐ Consultation and treatment
- ☐ Second orthodontic opinion
- ☐ Consultation only (possible treatment by general practitioner)
- ☐ Assessment for interdisciplinary treatment

Others: _____

Main Concern:

Dental Status

Caries Risk ☐ High ☐ Medium ☐ Low

Oral Hygiene ☐ Good ☐ Fair ☐ Poor

Teeth with Questionable/Poor Prognosis: _____

- ☐ Patient is dentally fit for orthodontic treatment.
- ☐ Radiographs enclosed ☐ OPG ☐ Lat. Ceph. ☐ Others

Relevant Medical History

☐ Nil ☐ Yes

Comments:

Signature: _____ **Date:** _____

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

ACAOO
Suite 38, Level 3, 650 George Street,
Sydney (World Square Complex)
T: (02) 9261 2121
F: (02) 9261 2131