

## 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:**

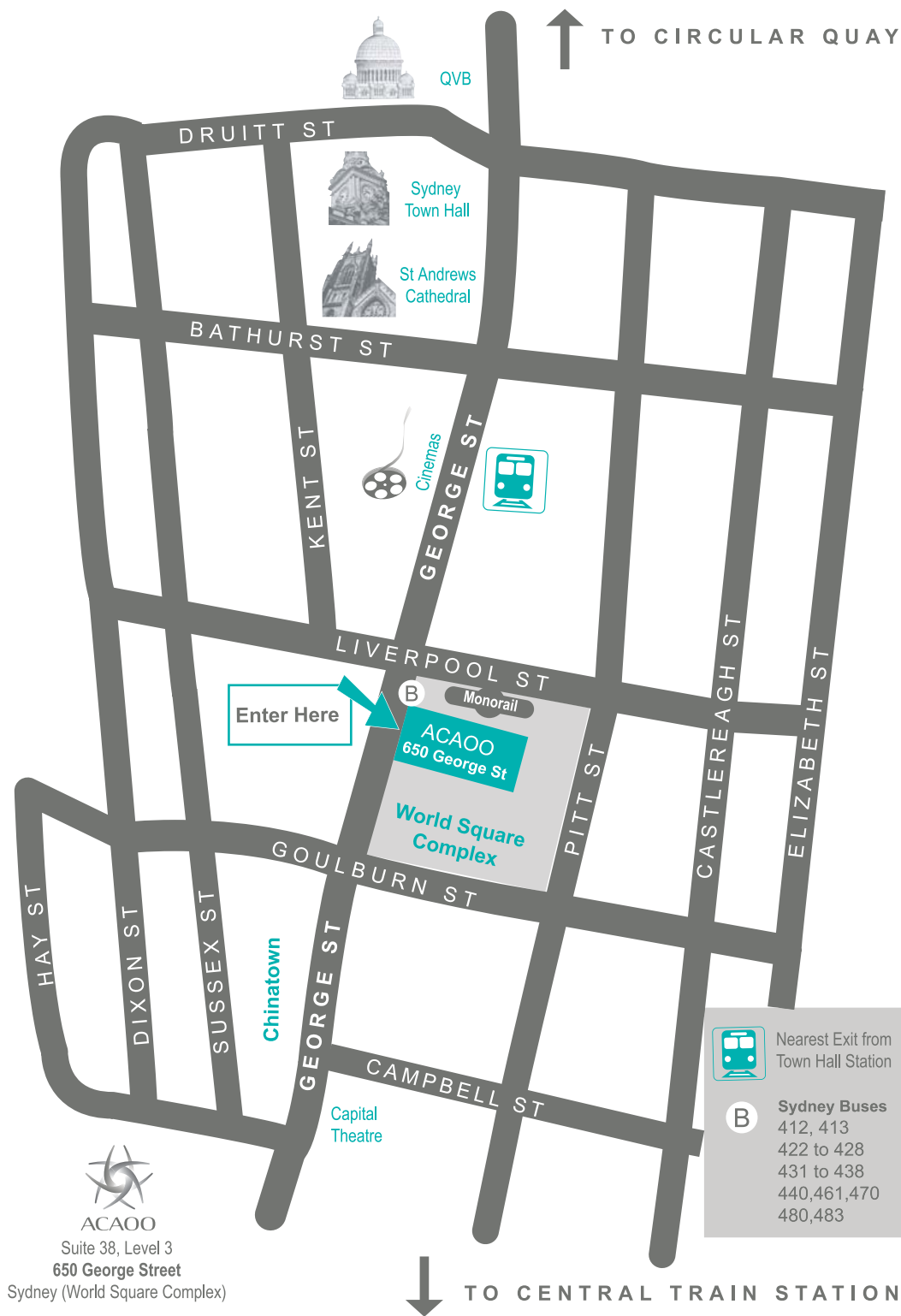
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\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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


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



  
ACAEO  
Suite 38, Level 3  
650 George Street  
Sydney (World Square Complex)

↑ TO CIRCULAR QUAY

↓ TO CENTRAL TRAIN STATION

 Nearest Exit from Town Hall Station

**B** Sydney Buses  
412, 413  
422 to 428  
431 to 438  
440, 461, 470  
480, 483