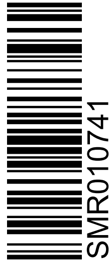

SMR010741

NSW GOVERNMENT | Health

Facility:

ORAL HEALTH SPECIALIST REFERRAL

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / _______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Indicate referral centre (✓)	Sydney Dental Hospital ☐	Westmead Centre for Oral Health ☐	John Hunter Hospital ☐	Other ______ ______
Postal Address	2 Chalmers St Surry Hills NSW 2010	PO BOX 533 Wentworthville NSW 2145	Locked Bag 1 Hunter Region Mail Centre NSW 2310	______ ______

Type of Specialist Service Required:

Patient Information:

Home number:	Mobile:	Work number:

Language spoken at home:		Country of Birth:

Interpreter required ☐ Yes ☐ No | Aboriginal Liaison Officer required ☐ Yes ☐ No

Medicare Card No. __ __ __ __ __ __ __ __ __ __ __ *(please provide all 11 numbers)*

Concession card: HCC or PCC *(please circle)*	**Card No:**	**Start date:**	**Expiry date:**

Referring Practitioner ☐ Medical ☐ Dental ☐ Other

Type: ☐ General ☐ Specialist Specialty ______

Name:

Address:

Telephone: Fax: Email:

Signature: Date:

Patient's Medical and Dental Information

1. Significant medical history: *(include any relevant access issues / special requirements / guardianship)*

2. Reason for referral and treatment history: (please ✓ the relevant box below to identify your request)

I request: ☐ an opinion ☐ opinion and management by a specialist ☐ general care (student only)

3. Provisional treatment plan:

4. Enclosures *(please identify type e.g. radiograph, reports)*

- ______
- ______
- ______

Office Use Only: Clinic/Dept: ______ Waiting List ______

Date entered: ______ Signed: ______

Holes punched as per AS2828.1:2012

BINDING MARGIN - NO WRITING

NH606531A 040714

ORAL HEALTH SPECIALIST REFERRAL

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