

FAMILY NAME	MRN
GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

SMR010741

Facility:

ORAL HEALTH SPECIALIST REFERRAL

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

D.O.B. ____ / ____ / ____ M.O. _____

ADDRESS _____

Indicate referral centre (✓)	Sydney Dental Hospital <input type="checkbox"/>	Westmead Centre for Oral Health <input type="checkbox"/>	John Hunter Hospital <input type="checkbox"/>	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

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