ILLAWARRA

paediatric dentistry

Name _____ D.O.B _____

Parent/Guardian _____

Phone _____

Medical history _____

_____

Reason for referral

- ☐ Caries
- ☐ Abscess
- ☐ GA/Behavioural management
- ☐ Other _____
- ☐ Tongue-tie
- ☐ Trauma
- ☐ Enamel defect

Further details _____

_____

_____

Radiographs ☐ Hard copy provided ☐ E-mailed to practice

- ☐ Management of the above condition and provision of ongoing care
- ☐ Management of the above condition with the patient returned to you for continued care

Referring practitioner _____

Practice name or email _____

Signature _____ Date _____

Dr Jason Michael
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