

REFERRED BY DR: _____	PROVIDER NO: _____
ADDRESS: _____	
TELEPHONE: _____	SIGNATURE: _____

This form must be completed by a registered dental and/or medical practitioner to be eligible for Medicare rebate for consultation.

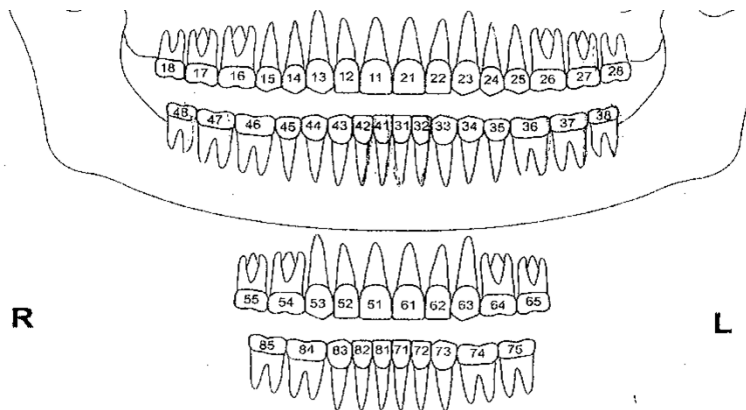
REFERRAL TO: Next available surgeon
 Dr Bruce Robinson Dr Miles Doddridge Dr Paul Sambrook
 Dr Tom Jaunay Dr Justin Collum Dr Glen Carter

DATE: _____
PATIENT NAME: _____
DOB: _____
PATIENT ADDRESS: _____
PATIENT EMAIL: _____
PATIENT PHONE: _____
CONSULTATION FOR: _____

SURGICAL REMOVAL

OF: _____

Please handwrite teeth numbers and also circle below.



- | | |
|--|---|
| <input type="checkbox"/> Exposure of indicated teeth
<input type="checkbox"/> Oral pathology
<input type="checkbox"/> Corrective jaw surgery | <input type="checkbox"/> Facial Fractures
<input type="checkbox"/> Preprosthetic oral surgery including Dental Implants (System preferred) |
|--|---|

Other reasons for referral or comments:

RADIOGRAPHS

- | | |
|--|---|
| <input type="checkbox"/> Radiographs posted to Oromax
<input type="checkbox"/> No Radiographs | <input type="checkbox"/> Radiographs given to patient
<input type="checkbox"/> Organised Radiograph for patient to bring |
|--|---|

YOUR CONSULTATION APPOINTMENT IS

AT: _____
ON: _____

*This appointment has been reserved specifically for you.
 Please contact 8232 3525
 if you need to change or cancel this appointment.*

Please assist us by providing the following information at the time of your initial consultation:

- Your referral and x-rays if applicable
- If you have medical or dental health insurance, please bring the necessary information
- A list of medications you are presently taking
- Your Medicare card
- Your GPs name, address and telephone number