

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

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

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

DATE: _____

PATIENT NAME: _____

DOB: _____

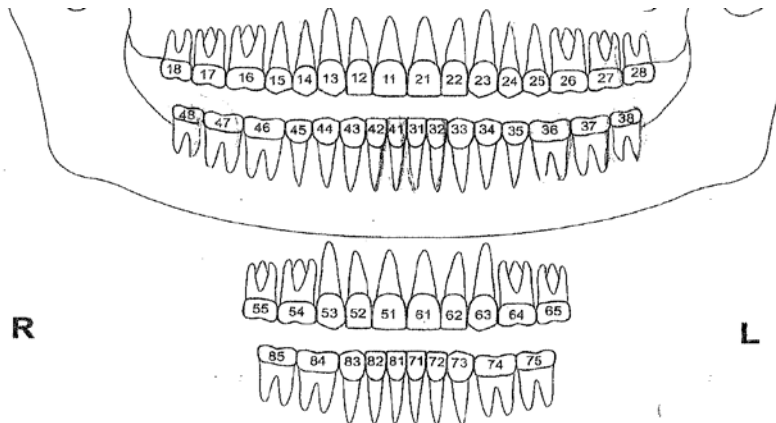
PATIENT ADDRESS: _____

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

Other reasons for referral or comments:

RADIOGRAPHS

- | | |
|--|---|
| <input type="checkbox"/> Radiographs post to EAOMC | <input type="checkbox"/> Radiographs given to patient |
| <input type="checkbox"/> No Radiographs | <input type="checkbox"/> Organised Radiograph for patient to bring4 |

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