Level 2, 66 Rundle Street
Adelaide SA 5067
P: 08 8232 3525
F: 08 8232 3527
E: reception@oromax.com.au

oro max clinic

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: ______________________

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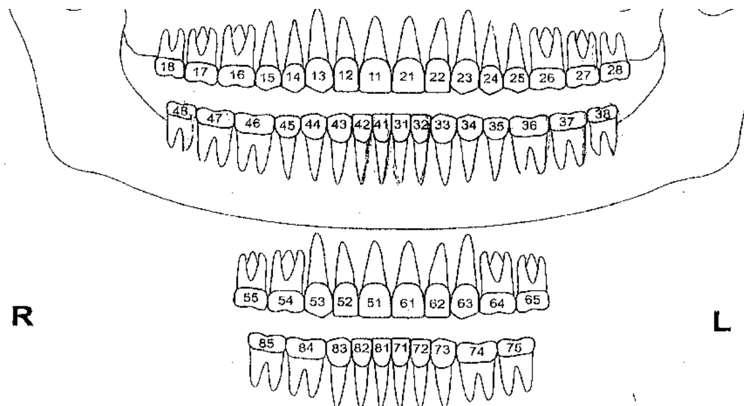
SURGICAL REMOVAL OF: ______________________

Please handwrite teeth numbers and also circle below.



- ❑ **Exposure of indicated teeth**
- ❑ **Oral pathology**
- ❑ **Corrective jaw surgery**
- ❑ **Facial Fractures**
- ❑ **Preprosthetic oral surgery including Dental Implants (System preferred)**

Other reasons for referral or comments:

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RADIOGRAPHS

- ❑ **Radiographs posted to Oromax**
- ❑ **No Radiographs**
- ❑ **Radiographs given to patient**
- ❑ **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
- A list of medications you are presently taking
- Your GPs name, address and telephone number
- If you have medical or dental health insurance, please bring the necessary information
- Your Medicare card