Referral for Opinion/Treatment

PATIENT NAME _____ DOB _____

ADDRESS _____ PHONE _____

MEDICAL HISTORY _____

- ☐ DENTAL CARIES
- ☐ DENTAL TRAUMA
- ☐ DENTAL EXTRACTIONS
- ☐ MINERALISATION DEFECTS
- ☐ DENTAL ANOMALY
- ☐ ORTHODONTICS/SPACE MAINTENANCE
- ☐ BEHAVIOUR MANAGEMENT
  - ○ TREATMENT UNDER SEDATION
  - ○ TREATMENT UNDER GA

ADDITIONAL COMMENTS _____

REFERRING DENTIST _____ PHONE _____

ADDRESS _____

Dr. Anuj Batra
Specialist Paediatric Dentist
BDS, DClinDent (Otago)

SIGNATURE _____

DATE _____

Paediatric Dental Home
SPECIALIST PAEDIATRIC DENTISTS

1300 100 PDH

61 Princes Highway, Werribee 3030 • 1 Isabella Street, Geelong West 3218

Fax: (03) 9017 3181 • enquiries@paediatricdentalhome.com.au • www.paediatricdentalhome.com.au