ILLAWARRA

paediatric dentistry

Patient's name _____ D.O.B _____

Parent's name _____ Ph _____

Referral for

- ☐ Dr. Jason Michael – Paediatric Dentist
  BDS BScDent(Hons) DClinDent(Paed) MRACDS(Paed)
- ☐ Dr. Sabrina Michael – Orthodontist
  BDS BScDent(Hons) DClinDent(Orth) MRACDS(Orth)
- ☐ Joint consultation

Reason for referral

- ☐ Caries
- ☐ Abscess
- ☐ Dental anxiety/RA/GA management
- ☐ Special needs
- ☐ Trauma
- ☐ Enamel defects
- ☐ Orthodontics
- ☐ Other

Further details _____

_____

_____

Radiographs ☐ Taken (*please email*) ☐ None taken

- ☐ 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

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