The **Specialist Paediatric Dental** Practice

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Specialist Paediatric Dentist
and Associates

Specialist Referral

Clinician: _____

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Reason for Referral: ☐ Caries/Cavities ☐ Abscess ☐ Trauma/Fracture
☐ Enamel Hypoplasia ☐ Over-Retained Teeth ☐ Supernumerary ☐ Other

Details: _____

_____

_____

_____

Treatment to Date: _____

_____

_____

Treatment Required: ☐ Restoration ☐ Stainless Steel Crown ☐ Fissure Sealant
☐ Pulpotomy ☐ Extraction/Surgical Removal

Medical History: _____

_____

_____

Objectives of Referral: ☐ Opinion Only ☐ Opinion & Management of Specific Condition
☐ General Care

Radiographs Attached: ☐ Bitewing ☐ Periapical ☐ Occlusal
☐ OPG ☐ Cephalogram ☐ Tomogram/CT

Referrer Name: _____

Phone: _____

Email: _____