

PATIENT REFERRAL

Dear Dr Barbara Carach BSc.,BDS.,Grad Dip Clin Dent., MDS (Melb)

Dear Dr Adam Leung BDS Hons (Melb), DCD Ortho (Adel)

I am referring _____

Address _____

Telephone _____ DOB _____

For:

- Consultation Only
- Consultation and treatment
- Second Opinion

Please Note:

- Patient is dentally fit for orthodontic treatment

Radiographs enclosed:

- None
- OPG
- Lat Ceph
- Other

Comments _____

Referring Practitioner _____

Address _____

Telephone _____ Date _____

PLEASE NOTE:
On future visits any changes to the above should be advised.

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