



Referring practitioner completes patient information and practitioner contact details.

### PATIENT INFORMATION

Medicare Card No. \_\_\_\_\_ Reference No. \_\_\_\_ (Number next to child's name on card)

Home phone No: \_\_\_\_\_ Mobile No: \_\_\_\_\_ Work No: \_\_\_\_\_

Interpreter required  Yes  No Aboriginal liaison officer required:  Yes  No

### REFERRING PRACTITIONER CONTACT DETAILS

Name: \_\_\_\_\_ Profession: \_\_\_\_\_  
(Please print) (GP, Practice Nurse, other)

Signature: \_\_\_\_\_

Practice Name & Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

### REASON FOR REFERRAL (optional)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### PARENT/GUARDIAN CONSENT TO FORWARD FORM

I consent to this form and my child's details being sent to the Public Oral Health Service. I am aware I will be contacted by the Public Oral health Service to arrange a dental appointment.

Parent / Guardian Name: \_\_\_\_\_

\_\_\_\_\_  
*Signature of parent / guardian* Date: \_\_\_\_\_

Referring practitioner faxes signed form to a centralised intake number for processing.

**FAX: 02 4320 3709**

Area Health Service office use only:

Processed on (date): \_\_\_\_\_

Destination AHS: \_\_\_\_\_



SMR010742

Holes punched as per AS2828-1999  
 BINDING MARGIN - NO WRITING