[Type here]

Acton Vale
DENTAL CENTRE

Specialist Prosthodontist Referral Form

Referring Clinician:

Name	
Practice Name	
Phone	
Email	
Date of Referral	

Patient Information

Patients Name	
Date of Birth	
Address	
Contact Number	
Email Address	

Medical History

Conditions	
Medication	
Allergies	

Referral Details

Discipline	Tooth wear ☐	Dentures ☐	Implants ☐
	Extractions ☐	Cosmetic Case ☐	Other:
Reason for Referral			
Please attach relevant radiographs and clinical photos			