# Hills & Country
## PAEDIATRIC DENTISTRY

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## Patient Referral Form

**Date of Referral:** / /

**Patient Name:** **DOB:** / /

**Address:**

**Contact Parent/Carer:**

**Phone Number:**

**Email Address:**

**Private Health Cover** Extras ◯ Hospital Cover ◯

**Eligible for CDBS:** Yes ◯ No ◯ **Medicare number:**

**Reason for Referral:**

**Any Relevant History Comments:**

**Radiographs taken:** Emailed ◯ OPG ◯ Bitewings ◯ PAs ◯

**Referring Practitioners Name:**

**Practice Name:**

**Phone Number:**

If possible, please call the rooms to schedule an appointment at the time of referral.