HOBART ORAL SURGERY

410 Main Road Glenorchy **6240 6744**

REFERRAL

Dr Yadir Singh
BDS DClinDent MRACDS FDSRCS

Referrer

Name: **Phone:**

Practice name/address:

Patient (Please attach radiographs including an OPG for any extractions)

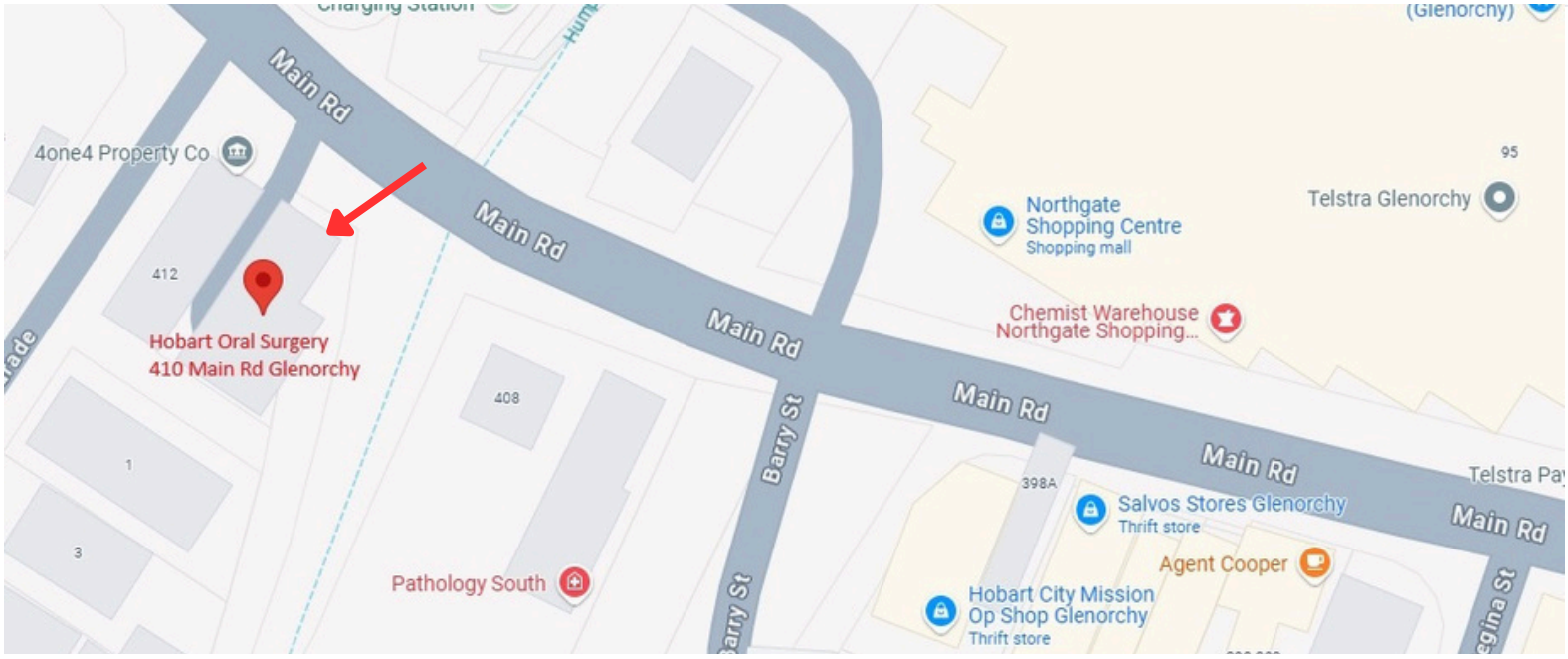
First name: **Surname:**

Patient DOB: **Phone:**

Regarding

- ☐ **Consultation**
- ☐ **Pathology/Biopsy**
- ☐ **Bone graft**
- ☐ **Tooth extraction**
- ☐ **Orthodontic exposure**
- ☐ **General anaesthetic/IV sedation consultation**
- ☐ **Wisdom teeth**
- ☐ **Dental implant**
- ☐ **Other:** _____
- ☐ **URGENT**

Please indicate the relevant tooth/teeth

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Relevant clinical notes and medical history (please attach radiographs or advise where an OPG has been taken)