REFERRAL FORM

smileteam orthodontics

Date: _____

Dear: _____

Re: _____

D.O.B: _____

Contact Details: _____

I WOULD LIKE TO REFER THE ABOVE CLIENT FOR ORTHODONTIC ASSESSMENT AND TREATMENT IF NECESSARY

The clients main concerns/reasons for referral are:

_____

_____

_____

☐ X-rays given to client

☐ X-rays given to customerservice@smileteam.com.au

☐ OPG ☐ Headfilm ☐ Other

Doctors Name: _____

Doctors Signature: _____

NOTE

Digital OPG and Headfilms are available at our Wollongong, Shellharbour, & Bowral Centres

WEB
www.smileteam.com.au

EMAIL
customerservice@smileteam.com.au

WOLLONGONG
149 Princes Highway
Fairy Meadow
NSW 2519
Ph: (02) 4220 5300

SHELLHARBOUR
10 College Avenue
Shellharbour City Centre
NSW 2529
Ph: (02) 4295 9100

BOWRAL
46 Station St
Bowral
NSW 2576
Ph: (02) 4861 7076

PARRAMATTA
13 Grose St
Parramatta
NSW 2150
Ph: (02) 9688 3588

DRUMMOYNE
204 Victoria Rd
Drummoyne
NSW 2047
Ph: (02) 9719 8820

BURWOOD
201 Burwood Rd
Burwood
NSW 2134
Ph: (02) 9744 8455

ADA MEMBER AUSTRALIAN DENTAL ASSOCIATION

Member Australian Society of Orthodontists