Special Needs Dentistry Australia

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Referral Form

PATIENT DETAILS

Full Name:	Date of Birth:
Email:	Contact Number(s):

Address:

REASON FOR REFERRAL

◯ Geriatric ◯ Intellectual ◯ Medically Complex ◯ Physical ◯ Psychiatric

Please specify conditions (attach any appropriate information):

Dental treatment required:

Please specify any other requirements/considerations:

CONSENT/GUARDIANSHIP DETAILS

Does the patient have the capacity to consent?

◯ Yes ◯ No ◯ Unsure

If not, please provide guardianship details:

Name:

Email:

Contact Number:

Type of guardianship: ◯ Health ◯ Finance

CARER/SUPPORT WORKER DETAILS

Name:

Email:

Contact Number:

OTHER

If possible, please provide:

◯ Health summary from medical GP or specialist, including hospital discharge papers

◯ Medication list

◯ Any existing dental records of relevance (e.g. previous radiographs/clinical findings)

REFERRING PRACTICE DETAILS

Referring Clinician:	Contact Number:
Practice Name:	Email:
Signature:	Date of Referral:

After completing specialist dental treatment, patients will be advised to return to their regular dentist for ongoing care, unless otherwise requested. Please email referral and relevant documents to **info@snda.com.au**