RCH Dental Clinic Referral Form

Fax referrals to – (03) 9345 5488

Email referrals to – [reception.dental@rch.org.au](mailto:reception.dental@rch.org.au)

Post referrals to – Dental Department

The Royal Children’s Hospital Melbourne

50 Flemington Road

Parkville Vic 3052

Telephone enquiries – (03) 9345 5344 (Monday – Friday 8.30am – 5.00pm)

**Patient Details**

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| --- | --- | --- |
| Patient surname: | Given name: | |
| Date of birth: | RCH UR number (If known to hospital) | |
| Gender: Male Female Other | | |
| Address: | | Postcode: |
| Parent/Carer surname: | Given name: | |
| Landline number: | Mobile number: | |
| Health care card number: | Expiry date: | |
| Interpreter required Yes No | Language: | |

**Clinical Details**

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| Reason for referral: |
| Clinical findings and investigation results: |
| Management to date: |
| Medical history and/or special needs: |
| Allergies: |
| Current medications: |
| This patient is being referred based on meeting the criteria below: (Please tick)   * Significant medical history and/or special needs * Congenital or acquired malformations of the orofacial region * Dental anomalies including Amelogenisis Imperfecta, Dentinogenesis Imperfecta & Ectodermal Dysplasia * Orthodontics for patients with craniofacial malformations, cleft lip and/or palate anomalies * Emergency – 24 hour on call service for children presenting with dento-facial injuries and facial cellulitis from acute infections which requires hospitalisation * Re-referral for patient that has been seen at RCH previously |

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| --- | --- |
| Given name: | Surname: |
| Specialty: | Provider number: |
| Practice name and address: | |
| Telephone number: | Fax number: |
| Doctors signature: | Date: |

**Referring Doctor Details**