RCH Dental Clinic Referral Form

Fax referrals to – (03) 9345 5488

Email referrals to – 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**