ORAL HEALTH CENTRE
OF WESTERN AUSTRALIA

OHCWA REFERRAL FORM

Referred from ☐ ALB ☐ ARM ☐ BBY ☐ GDC ☐ GLD ☐ LDC
☐ MID ☐ MH ☐ MOR ☐ NPC ☐ RCK ☐ RNG
☐ VAS ☐ WWK

Or Other ……

REFERRING DENTIST …… POSITION……

PATIENT NAME …… REGISTRATION NO ……..
(SURNAME) *(GIVEN NAME)*

DATE OF BIRTH ……..

ADDRESS ……
…… POST CODE …….

TELEPHONE NO …… MOBILE ……..

Referred for ☐ ENDO ☐ ORAL MED** ☐ ORAL SURG. ☐ ORTHO
☐ PAEDO ☐ PERIO ☐ SPEC. REST ☐ STUDENT ☐ OTHER_____

Urgency ☐ HIGH ☐ MEDIUM ☐ WAITING LIST

Details ……
……
……
……
……

Relevant Medical History ……
……
……
……
……

If Oral Surgery for 8's	Number of Teeth	Distal Impact (Y/N)
Upper	……	……
Lower	……	……

Requires general anaesthetic? ☐ Yes ☐ No ☐ Unsure

Why? ……

Signature …….. Date ……..

Please enclose copies of –
(1) Relevant x-rays (eg. OPG for oral surgery)
(2) Patient eligibility forms
(3) Any relevant laboratory tests and specific medical history **

Updated January 2012