Oral Health Referral Form

CHILD'S DETAILS

Family Name: …… First Name: ……

Address: ……..

……

Child's Medicare No: _ _ _ _ _ _ _ _ _ _ _ (11 digits) M/F……. Date of Birth: .....

Aboriginal / Torres Strait Islander: ☐ Other: ☐

Interpreter required: ☐ Yes ☐ No If yes, which language: ……..……

PARENT/GUARDIAN DETAILS

Name: ……..

Relationship to child: ……..

Mobile Phone No: …….. Hm/Wk Phone No: ……

I give consent for the Public Oral Health Service to use this information.

Signature: …… **Date:** ……

ORAL HEALTH ASSESSMENT*(tick boxes)*	**ACTION**
☐ Trauma or facial swelling	Immediate transfer to Centralised Oral Health Intake and Information Service (COHIIS) 9293 3333
☐ White spot demineralisation	Refer to Early Childhood Oral Health Coordinator. Email: SLHD-SDHSpecialistReferrals@health.nsw.gov.au
☐ Cavitated lesions (holes)	
☐ Family requires oral health support	
☐ Frequent snacking (especially high sugar intake)	Discuss with parent and record findings Re-assess need for referral at next scheduled health check
☐ Child takes a bottle to bed (or uses at will by day)	
☐ Special health needs / frequent medications	
☐ Visible plaque	

REFERRED BY (Health Professional)

Name and Title: ……..

Phone No: …….. Fax No: ……

Email: ……

Postal Address (if required for feedback): ……..

Additional information……

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