Dr Susan Hinckfuss

B.D.Sc (Melb), D.C.D (Melb)

Specialist Paediatric Dentist

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Date of referral: .....

Patient Name: ..... D.O.B .....

Address: ..... Phone: .....

Medical History: .....

Please provide consultation for

❒ Dental Caries ❒ Trauma ❒ Pulpitis/Abscess

❒ Malocclusion ❒ Enamel Defects ❒ Space Maintenance

❒ Other

Behaviour ❒ Calm ❒ Anxious ❒ Uncooperative

General Anaesthesia may be required ❒ Yes ❒ Maybe ❒ No

Comments: .....

.....

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Radiographs Enclosed ❒ OPG ❒ BW's ❒ Periapicals

Please Manage ❒ Initial course of treatment

❒ Until patient cooperative

❒ Until permanent dentition completely erupted

Referring Practitioner

Name: .....

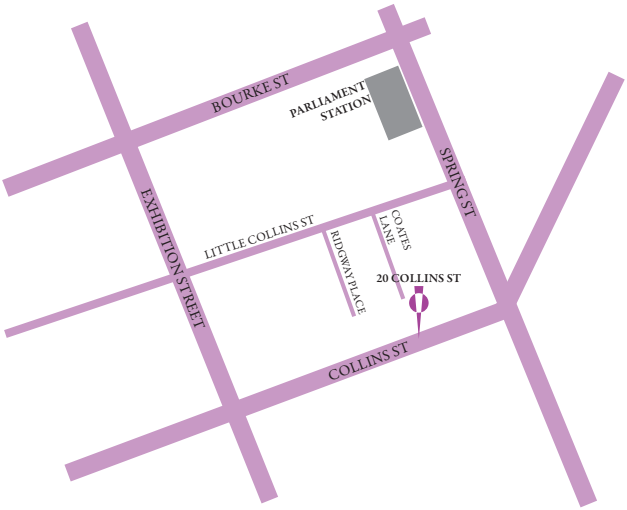
Address: .....

Telephone: ..... Email: .....

Location & Directions:

PRACTICE LOCATIONS

20 Collins St, Melbourne



77 Stud Rd, Dandenong