REFERRAL

PATIENT

ADDRESS

TELEPHONE DATE OF BIRTH SEX ☐ M ☐ F

REFERRED BY DATE

PURPOSE OF REFERRAL

☐ Crowding ☐ Spacing ☐ Open bite ☐ Perio/ortho concerns

☐ Crossbite ☐ Deep bite ☐ Missing/Extra teeth ☐ Pre-restorative concerns

☐ Reverse overjet ☐ Excessive overjet ☐ Second opinion

ACTION REQUIRED

☐ Advice and necesary treatment ☐ Please discuss with patient alternative treatments ☐ Opinion

☐ Other (specify)

FOLD

SOUTH YARRA ORTHODONTICS

SPECIALIST ORTHODONTIST

DR THERESIA R. SUDJALIM

B.D.SC.(MELB), D.C.D.(MELB), F.R.A.C.D.S., M.ORTH R.C.S.(EDIN), M.R.A.C.D.S.(ORTH), A.O.B.(CERT.)

SYORTHO.COM.AU
LEVEL 1, 6 BOND ST,
SOUTH YARRA VIC 3141

03 9131 1999
INFO@SYORTHO.COM.AU
ABN 31 309 570 694

Love your smile

COMMENTS

PLEASE GIVE LOWER PORTION TO PATIENT. DETATCH, FOLD AND MAIL UPPER PORTION

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INTRODUCING

REFERRED BY

APPOINTMENT

DATE

TIME

During the examination appointment I will discuss your orthodontic problems then determine whether or not correction is required, when it would be best to begin, the type of appliance, the time required for treatment, and outline the fees. My staff and I will be glad to assist you with financial arrangements.

Your appointment time is reserved especially for you. Parents or guardians should accompany children and adolescents to this visit.

Please note that bite wing radiographs and regular fluoridation and cleanings are desirable for all patients who are to undergo orthodontic treatment. These are performed by your general dentist.

A map, with our office location highlighted, is on the reverse side.