



REFERRAL FOR SURGICAL OPINION / MANAGEMENT

Dear **Dr Sam Vecro** / **Dr Brent Woods**
Next available surgeon

Date : _____

I wish to refer to you _____

Date of Birth _____ Telephone _____

Patient's Relevant Medical History _____

For consultation and treatment regarding

- | | |
|---|---|
| <input type="checkbox"/> Surgical Removal of indicated teeth or roots | <input type="checkbox"/> Orthognathic (Corrective Jaw) Surgery |
| <input type="checkbox"/> Implants to replace Tooth / Teeth | <input type="checkbox"/> Pathological Lesions in the Mouth / Jaw(s) |
| <input type="checkbox"/> Facial Injury | <input type="checkbox"/> Temporomandibular Joint Condition |

Please specify

ALL APPOINTMENTS PLEASE CALL 03 9592 6445

Referral by Dr. _____ Provider Number _____

Address _____

Signature _____

RADIOGRAPHS Enclosed Emailed To be obtained

Referral valid for 12 months Indefinite

Appointment Location 759 Nepean Hwy, Brighton East, VIC 3187

350 Main Street, Mornington VIC 3931