A/Prof Harleen Kumar
SPECIALIST PAEDIATRIC DENTIST

BDSc DCD (Paed Dent) FPFA
Clinical Associate Professor, School of Dentistry,
Faculty of Medicine and Health,
The University of Sydney

Referral Form

Date .....

PATIENT INFORMATION

Name of Child ..... Date of Birth .....

Gender ..... Parent's Phone .....

Email .....

Address .....

Parent 1 Name ..... Parent 2 Name .....

REASON FOR REFERRAL *(Add any relevant information)*

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Medical History .....

Treatment	◯ Opinion only	◯ Opinion and management	◯ Management and ongoing care
Radiographs or Imaging	◯ Not applicable	◯ To be emailed	◯ With patient
Anaesthetic Preference	◯ Local anaesthesia / Nitrous oxide	◯ General anaesthesia	

REFERRER DETAILS

Practitioner Name ..... Contact Phone .....

Practice Name ..... Email .....

Practice Address .....



Kids Dental Sydney

Dentistry for Infants, Children and Adolescents

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