auckland family dental
care. trust. confidence. respect.

Paediatric Referral Form

Please complete the form below and email to kids@aucklandfamilydental.co.nz
(You can also complete this form at www.aucklandfamilydental.co.nz/paediatric-referral-form)

Auckland Family Dental
Dr. Angel Babu
Specialist Paediatric Dentist
DClinDent (Otago)

Patient / Guardian Details

Patient Name: ____ DOB: ____ / ____ / _____

Guardian Name: ____

Address: ____ Post Code: __________

Phone: ______________________________ Mobile: ____________________________

Email: ____

Reason for Referral + Additional Notes

Consultation: ☐ Caries/Abscess: ☐ Trauma: ☐
Mineralisation Defects: ☐ Dental Anomaly: ☐ Surgical Management: ☐
Special Needs: ☐ GA/Behavior Management: ☐ Oral Pathology: ☐
Other: ☐ ____

Comments : ____

____

Medical and Dental History

____

____

ACC Details (If Applicable)

Claim Number/ACC42 Number: ______________________________ Date of Accident: ____ / ____ / ______

Radiographs Taken / Enclosed

PBW's ☐ - YES ☐ - NO
OPG ☐ - YES ☐ - NO

Referring Dentist Details

Dr.: ____

Address: ____ Post Code: __________

Work Phone: ____________________ Email: ____________________________________

Please Select Clinic below and email:

Drury :	217 Great South Road, Drury, 2113	(09) 294-7761	☐
Milford :	2 Dodson Avenue, Milford, 0620	(09) 489-8354	☐
New Lynn :	14 Delta Avenue, New Lynn, 0600	(09) 826-1664	☐
Botany :	455/D East Tamaki Road, Botany, 2013	(09) 666-0018	☐