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ONLINE REFERRAL FORM

We sincerely appreciate your trust, and are looking forward to working with you to ensure that your patients get the best possible care. Please fill in the form below. We will contact your patient within 24hrs of receiving your referral, to schedule their appointment.

Patient Name

Patient Contact Number

Referred To: ☐ Dr Michael Chang ☐ Dr Ghada Soliman

Referred For:

- ☐ Implant surgery & restoration
- ☐ Implant surgery only
- ☐ Implant restoration only
- ☐ Sleep bruxism
- ☐ Consultation only
- ☐ Complex restoration
- ☐ Aesthetic improvement
- ☐ Worn dentition
- ☐ Full mouth rehabilitation
- ☐ TMD
- ☐ Treatment and ongoing management
- ☐ Xrays with patient

Clinical Notes

Referred by

Patient Suburb

Contact Number

Please attach any supporting radiographs, photographs and other documents

Phone me to discuss this case

☐ Before ☐ After seeing the patient

To receive a copy of this referral letter, please provide your email address

To be added to our study club and exclusive events list, please provide your personal email

Signature and Date