



To, Dr. Anand , B.D.S(Adel), M.Clin.Dent (Prosthodontics) (London)
email: anand.patel@bigpond.com

Extreme Dentistry
12 Orchard Road Coconut Grove NT 0810
Ph 08 8948 1225, Fax 08 8948 5233

Patient:DOB//
Address:Ph:
Previous Treatment.....
Medical History of Note.....
Other

Dental Referral for: (Please tick the relevant)

- ☐ Assessment and Management of Dental and Oral Health
- ☐ Assessment and Management of Wisdom teeth
- ☐ Assessment and Management of Tooth wear
- ☐ Assessment and Fabrication of Adjustable Mandibular Advancement Splint
- ☐ Consultation /Assessment on Tooth replacement / Rehabilitation
- ☐ Root Canal Therapy on tooth _____
- ☐ Endodontic Surgery on tooth _____
- ☐ Assessment and management of Dental Esthetics
- ☐ Assessment and Management of Denture related problems
- ☐ Assessment and Management of Dental treatment under sedation
- ☐ Assessment and Management of Periodontally compromised Dentition
- ☐ Other

From, Dr.Provider #.....
Surgery
Ph:ext. Date//
Fax:..... e mail