peninsula ORTHODONTICS

Dr Doug Lee
BDSc, MDSc (Ortho) (Melb)

Dr Alan Tran
DDS (Melb), DCD (Ortho) (Melb),
AOB Cert

ORTHODONTIC REFERRAL

Date _____ Patient Name _____

From _____ Date of Birth _____

_____ Address _____

Practice Name _____ _____

Phone _____ Phone _____

Email _____ Email _____

Clinical concerns

- ◯ Orthopaedics (early treatment)
- ◯ Crowding
- ◯ Cross bite
- ◯ Narrow upper jaw
- ◯ Class I
- ◯ Class II (dental / skeletal)
- ◯ Class III (dental / skeletal)
- ◯ Other

Comments _____

OPG (Tick all that apply)

◯ Emailed to: smile@peninsulaortho.com.au ◯ OPG referral given ◯ OPG not yet requested

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134 Tanti Avenue
Mornington 3931
Victoria Australia
T 61 3 5975 5166
F 61 3 5975 5177
smile@peninsulaortho.com.au
peninsulaortho.com.au