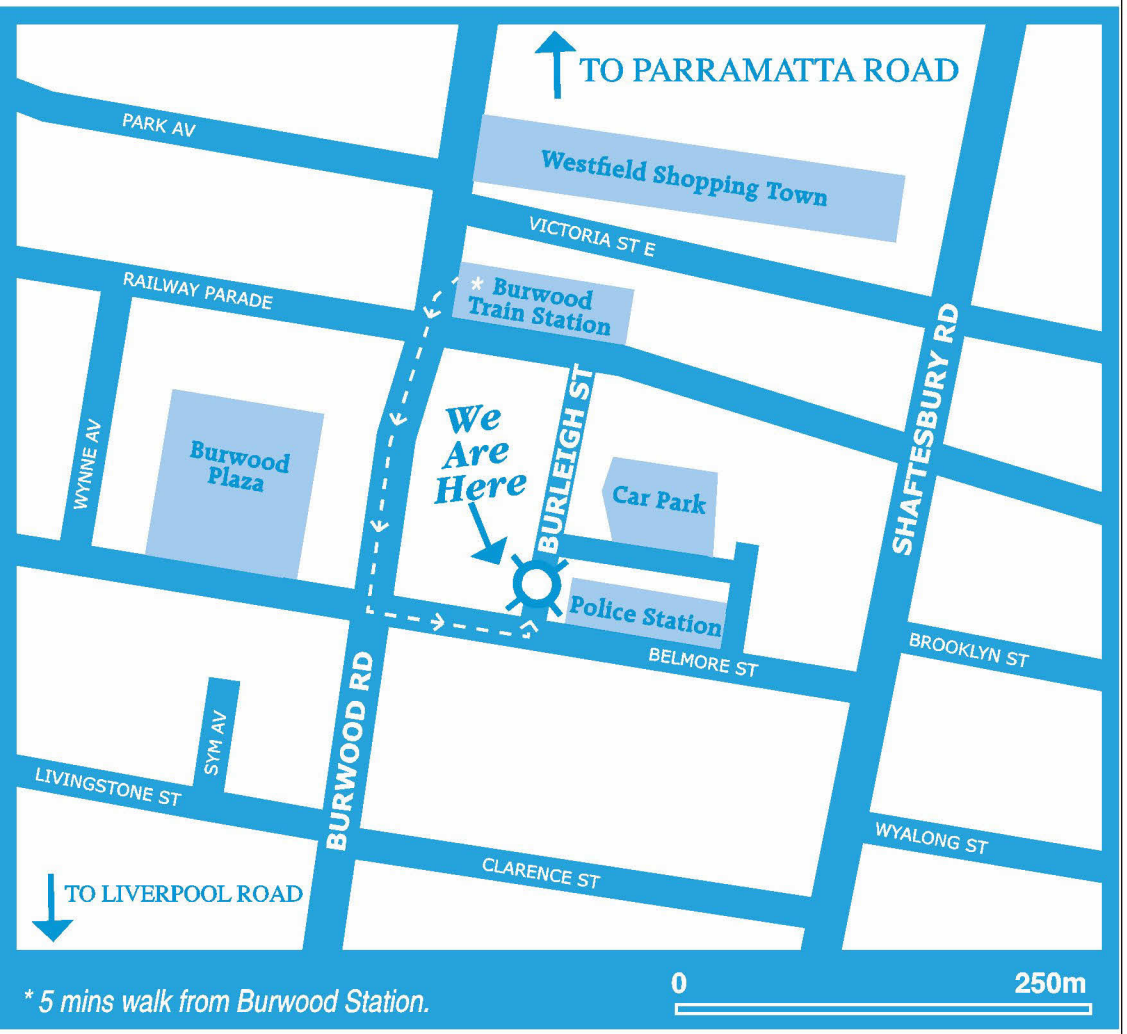

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GARETH HO orthodontist

DR. GARETH HO
SPECIALIST ORTHODONTIST
BDS, MDSc, MDSc(Orthod), FRACDS, MRACDS(Orth), MRACDS(Paed)

REFERRAL FORM

Referring Practitioner	Patient
Doctor: _____	Name: _____
Tel: _____	Date of birth: _____
Address: _____	Tel: _____ Sex: ☐ M ☐ F
_____	Address: _____
_____	_____

Purpose of Referral

- ☐ Consultation and treatment
- ☐ Second orthodontic opinion
- ☐ Invisalign Assessment
- ☐ Assessment for multi-disciplinary treatment

Others: _____

Main Concern:

Dental Status

Caries Risk ☐ High ☐ Medium ☐ Low
Oral Hygiene ☐ Good ☐ Fair ☐ Poor
Teeth with Questionable/Poor Prognosis: _____
☐ Patient is dentally fit for orthodontic treatment.
☐ Radiographs enclosed ☐ OPG ☐ Lat. Ceph. ☐ Others

Relevant Medical History

☐ Nil ☐ Yes

Comments:

Signature: _____ **Date:** _____

Patient: Please bring this referral letter with you to your consultation.