Melbourne Oral Medicine and Facial Pain Centre

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Referral form

From

Doctor: ..... Clinic.....

Address: ..... Email.....

Patient's details

Name:.....Date of Birth: ...../...../.....

Address:.....Mobile .....

Email:.....

Reason for referral

☐ Oral Mucosal disease ☐ TMD and bruxism

☐ Oral Potentially Malignant Lesion ☐ Facial pain or neuralgia

☐ Snoring and Sleep Apnoea Appliances

Details of the referral

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Please direct patient to fill in the registration form, available online at
https://melbourneoralmedicine.com.au/for-patients