



Dr Nita Pai BDS (Adel), MDS (Adel)  
Paediatric Dentist

## PATIENT REFERRAL

This is to introduce: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_

Purpose for Referral:

- Consultation and management of specific condition
- Consultation, management and ongoing preventive care

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

X-Rays Enclosed:  Yes  No

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

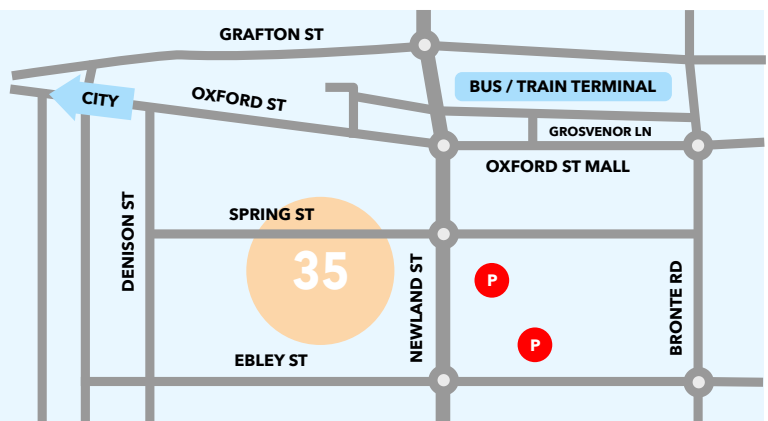
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Dentistry for Infants, Children and Adolescents