REFERRAL FORM

HKUDentistry
Institute for Advanced Dentistry
Multi-Specialty Clinic
先進牙醫學研究所
香港大學牙醫專科診所

Date .....

Referral Clinic .....

Referring Dentist .....

Telephone ..... Email .....

Patient Name .....

Patient Contact ..... Date of Birth .....

SPECIALTY TO BE REFERRED:

☐ Endodontics ☐ Orthodontics ☐ Implant ☐ Paediatrics

☐ Periodontics ☐ Prosthodontics ☐ OMFS

DIAGNOSIS

SERVICE REQUESTED

Referring Dentist Signature .....

2/F, Novum West, 460 Queen's Road West, Shek Tong Tsui, Hong Kong **T** 3979 9191 **F** 3979 9178 **E** referral.iad@hku.hk **www.iad.hku.hk**