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 .....

香港石塘咀皇后大道西460號翰林峰2樓（香港大學站B1出口）

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