


**Patient Information**

Name: \_\_\_\_\_ ID No.: \_\_\_\_\_ Phone: \_\_\_\_\_

**Referred For**

Endodontics		Periodontics			Paediatric Dentistry			
<input type="checkbox"/> Root Canal Treatment/ Retreatment <input type="checkbox"/> Endodontic Surgery <input type="checkbox"/> Management of Cracked Teeth <input type="checkbox"/> Regenerative Endodontics Treatment <input type="checkbox"/> Management of Dental Trauma <input type="checkbox"/> Other		<input type="checkbox"/> Periodontal Examination <input type="checkbox"/> Root Surface Debridement (Root Planing) <input type="checkbox"/> Gingival Grafting (Gingival Recession) <input type="checkbox"/> Periodontal Regeneration (Bone Grafting) <input type="checkbox"/> Dental Implant/ Peri-Implant Disease <input type="checkbox"/> Other			<input type="checkbox"/> Dental Caries/ Fluoride Therapy <input type="checkbox"/> Pulp Therapy <input type="checkbox"/> Tongue/ Lip Tie Release <input type="checkbox"/> Dental Sedation <input type="checkbox"/> Myobrace/ Space Maintainer <input type="checkbox"/> Other			
Imaging	Oral Surgery		Prosthodontics			Orthodontics		
<input type="checkbox"/> Periapical/ Bitewing <input type="checkbox"/> DPT/ OPG <input type="checkbox"/> CBCT <input type="checkbox"/> Lateral Ceph <input type="checkbox"/> Other	<input type="checkbox"/> Removal of Impacted Teeth <input type="checkbox"/> Biopsy/ Cyst Removal <input type="checkbox"/> Sinus Lift/ Ridge Augmentation <input type="checkbox"/> Pre-Prosthetic Surgery <input type="checkbox"/> Other		<input type="checkbox"/> Dentures <input type="checkbox"/> Full Mouth Rehabilitation <input type="checkbox"/> Fixed Prosthodontics <input type="checkbox"/> Veneers/ Aesthetics <input type="checkbox"/> Other			<input type="checkbox"/> Fixed/ Removable Appliances <input type="checkbox"/> Invisalign <input type="checkbox"/> Orthognathic Evaluation <input type="checkbox"/> Transfer/ Continuation Cases <input type="checkbox"/> Other		

Tooth/ Region:	8	7	6	E	D	C	B	A	A	B	C	D	E		
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7
				E	D	C	B	A	A	B	C	D	E		

 Attachment(s)  Radiograph  CT images  Other

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

 Refer to referring dentist after treatment

**Referred By**

Dentist Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Specialists**

Endodontist	Periodontist	Oral and Maxillofacial Surgeon	
<b>Dr. Chow Ai Tee</b> BDS (UM), MDS (Endo)(Singapore), MEndo RCS (Edinburgh), MFDS RCS (Edinburgh)	<b>Dr. Ten Li Hua</b> BDS (UM), MCLinDent (Periodontics)(UK), MPerio RCS (Edinburgh), MFDS RCS (Edinburgh)	<b>Dr. Daniel Lim Khim Hock</b> BDS (UM), MCLinDent (Oral and Maxillofacial Surgery) (UM)	
Orthodontist	Prosthodontist	Paediatric Dental Specialist	
<b>Dr. Eugene Yeoh Zhen Herr</b> DDS (UKM), DCLinDent (Orthodontics) (UKM), MFDS RCS, MOrth RCS (Edinburgh), MOrth RCPS (Glasgow)	<b>Dr. Ranganayakidevi</b> BDS (Saveetha), MCLinDent (Restorative Dentistry in Prosthetic) (UM), MFDS RCS (Edinburgh)	<b>Dr. Lim Siau Peng</b> DDS (USM), MCLinDent (Child Dental Health) (UM), MFDS RCS (Edinburgh)	<b>Dr. Tan Wei Xi</b> DDS (UNPAD), DCLinDent Paediatric Dentistry (London) MPaedDent RCS, MFDS RCS (Edinburgh)