



NORTH SHORE ORAL MEDICINE

Return via email to
northshoreoralmed@gmail.com

Dr Elizabeth Arena

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Oral Medicine Specialist

PATIENT REFERRAL

Date: ____ / ____ / 20 ____

PATIENT DETAILS

Name: _____ DOB: _____

Address: _____

Phone number: _____

Email: _____

REFERRING CLINICIAN DETAILS

Name: _____

Practice address: _____

Practice phone number: _____

Practice email: _____

REASON FOR REFERRAL

Please specify concern: _____

Relevant medical history and medications: _____

**Where possible, please attach all relevant information including dental radiographs, clinical photographs, other imaging reports and existing pathology/blood results*

**Please attach recent patient Health Summary*

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North Shore Health Hub

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