



affinity periodontics
& implant dentistry

Adj. A/Prof. Melinda Newnham

BDSc(WA) FRACDS DCD(Perio) FRACDS(Perio) FADI FITI FPFA FICD
Periodontist

Referrer's Name:

Date of Referral: / / Referrer's Tel:

Re: Patient's Name:

Patient's Address:

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Date of Birth: / / Phone:

I would like to refer this patient to you for specialist management:

☐ Periodontal assessment and management.....

☐ Specific assessment and management of area.....

☐ Implant assessment and management for tooth.....

☐ Aesthetic crown lengthening of tooth.....

☐ Crown lengthening for restoration of tooth.....

☐ Frenectomy.....

☐ Other:.....

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Located at **Ascot Vale Dental:**
Tel 9372 8007

97 Union Road ASCOT VALE Victoria 3023
Email reception@affinityperio.com.au

www.affinityperio.com.au