If you are a MAC user the "submit email" function will not work. Please fax completed form to 07 578 5485

Please use your individual login to activate fields

Referral – Community Dental Services
Community Child & Youth Health Services

Private Bag 12024, Tauranga. Fax: 07 578 5485 Phone: 07 577 3335

Please check that the Parent / Caregiver wants to use the BOPDHB Community Dental Service before completing this form. *If not please on-refer to Te Manu Toroa – Only for Western BOP region*

Referrer Details:

Organisation Name:		Referral Date:	
Referrer Name:		Referrer Phone:	
Referrer Position:		Email Address:	

Child's Details:

Child's Firstname:		Child's Surname:	
Date of Birth:		NHI:	
Parent/Caregiver Name:			
Relationship to child:			
Address:			
Phone Number:		Work Number:	
Cell Phone Number:			
Preschool Name:		School child will be enrolled with:	

Child's "Lift the Lip" Assessment grade

The progression of Decay	
Plate - 1	
Plate - 2	
Plate - 3	
Plate - 4	
Plate - 5	
Plate - 6	

Preschool Dental Administrator – please complete and send response back to the referring Nurse / Community Health Worker

Date referral received:		
Date assessment appointment made:		
Assessment wait listed:	☐ Yes	☐ No