**Referring Company or Organisation Logo**

*Referral to Community Outreach Dental Clinic at Common Ground-*

*73-79 Light Square Adelaide 5000****-*** *Ph.- 82051618*

To whom it may concern,

Community Outreach Dental Clinic

University of Adelaide

I refer (full name)........................................... of (address)........................................... contact number ................................................ alternate contact details ...............................................

Name ...............................has been having the following dental problems.......................................

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I/we would be grateful if he /she could be seen at your clinic due to the following circumstances (any information regarding financial and shelter vulnerability and any health issues)

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*The client has been advised that any donation would be gratefully accepted, but not mandatory*.

Clients’ Signature.......................................................................................................

Should you require further information please contact.

Referees name and contact details....................................................

Referees Signature………………………………………………………………………….

Position held........................................................

Date.............................................................................

(Please attach any other relevant information pertaining to the client)