SA Dental

Government of South Australia

Lift the Lip Referral Form

Complete details below (please print):

Parent/Guardian's Name ..... Phone .....

Child's Name ..... Date of Birth .....

Address .....

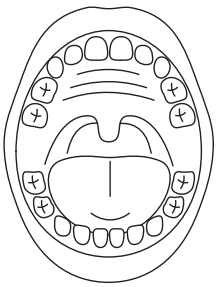
Referrer details

Name ..... Phone .....

Organisation/Address .....

Email ..... Signature .....

Reason for referral

Early or advanced signs of tooth decay ☐ Pain/infection ☐ Unable to conduct screen ☐ Other (please describe): ☐	Please use comment option on right, to indicate area of concern using drawing tool  R L
Has the child previously attended a SA Dental or private dental clinic? If yes, where?.....	
Is the child of Aboriginal and/or Torres Strait Islander descent? Yes ☐ No ☐	

☐ Parent/Guardian would like their child to attend SA Dental. Clinic staff will contact Parent/Guardian to arrange an appointment for a complete dental check.

☐ Parent/Guardian would like their child to attend a private dental clinic. Parent/Guardian to arrange their child's dental appointment.

Parent/Guardian consent

I consent to this information being shared with SA Dental. I understand that SA Dental may contact me about my child's oral health or evaluation of this Program. Lift the Lip is not a complete dental check. First dental visits are still recommended at 12-18 months.

Signature ..... Date .....

OR Verbal Consent provided Yes ☐

Please email ALL completed referrals to: HEALTH.SADSLifttheLip@sa.gov.au

Contact the Lift the Lip Project Team on (08) 7117 0072 if you have any questions.