



OFFICIAL: Sensitive



Lift the Lip Referral Form

Complete details below (please print):

Parent/Guardian's Name Phone

Child's Name Date of Birth

Address Postcode

Medicare Number IRN Expiry Date

Referrer details

Name Phone

Organisation/Address

Email Signature

Reason for referral

<p>Early or advanced signs of tooth decay <input type="checkbox"/></p> <p>Pain/infection <input type="checkbox"/></p> <p>Unable to conduct screen <input type="checkbox"/></p> <p>Other (please describe): <input type="checkbox"/></p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>If possible, please mark area of concern</p> <div data-bbox="1082 999 1299 1276"></div> <p>R L</p>
<p>Has the child previously attended a SA Dental or private dental clinic? If yes, where?</p>	
<p>Is the child of Aboriginal and/or Torres Strait Islander descent? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	

- ☐ 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.

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