SPECIAL NEEDS DENTAL TEAM

SND Specialists	Provider no.	Dentists	Provider no.
(1/12) Dr Kerrie Punshon	055216EY	(13) Dr Catherine Fu	4756955A
(3) Dr Warren Shnider	053069DK	(24) Dr Agam Kaur	5860171F
(14) Dr Hajer Derbi	4867926F	**Oral Health Therapist**	
(15) Dr Nikki Liew	297729AA	(12) Ms Natalie Martyn	

43 Blackburn Rd
PO Box 89
Blackburn VIC 3130
Email: Admin@drkerrie.com.au
Tel: (03) 9877 8035
Fax: (03) 9878 1831
www.specialneedsdental.com.au
ABN: 48 542 307 261

Specialists in Special Needs Dentistry
43 Blackburn Rd
Blackburn 3130

MEDICAL QUESTIONNAIRE

Surname (patient):……Given Names:……
Address:……
Phone/fax/e-mail:……

Name of General Medical Practitioner:……
Address: ……
Phone/fax/e-mail:……

Please forward a copy of your current medical summary/medical admission forms (from your Medical Practitioner) along with a copy of your medications list and drug chart including all PRN medications. This needs to be completed before the first visit (please contact your Medical Practitioner)

Name of your previous Dentist: ……
Address: ……
Phone/fax/e-mail:……

Is the patient capable of understanding and following instructions? Select
Do you smoke, if yes, how many a day and for how many years? Select
Do you drink alcohol, if yes how many standard drinks per week? Select

Please list anything you are allergic to: ……

Please list any prescription or over the counter medication you are taking, and enclose a copy of your current medications chart from GP/Residential Care Facility
……
……
……
Name, address and phone/fax/e-mail of any Specialists you see including their specialties:
……
……
……

Sensory Issues: If yes, please explain further
……
……
Social Stories – we can provide pictures of the clinic on request.

Is there anything else that you need to tell the Dentist about? Select

If YES, to any of the above questions, please provide details and any other relevant information: (for example: Please give suggestions regarding treatment methods of communication, if appropriate)

Under Victorian Privacy legislation, Special Needs Dental Team can only speak to **authorised** persons about the above patient and their dental care. If there is anyone else that you would like to have authority to talk to us on your behalf, please provide their name and contact details. If we are contacted by family members or others about your dental care, we can't speak to them unless this authority is obtained first.

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MEDICAL QUESTIONNAIRE – Page 2

Surname (patient):……Given Names:……
Address:……..…….....……
…….....
Phone: …….…….…….....

Does this patient have a MEDICAL DECISION MAKER and/or ADVANCED CARE DIRECTIVES?

Select

If **YES**, please attach a copy.

Does this patient have an ORAL CARE PLAN and/or HOME ORAL CARE PLAN?

Select

If **YES**, please attach a copy.

Does this patient have ANY MANAGEMENT PLANS?

Select

If **YES**, please attach a copy.

We ask that patients come in with a carer that supports them regularly.