REFERRAL FROM _____

DATE _____

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Information sheet

Community Oral Health Service

This information will remain confidential to the Community Oral Health Service and will be securely stored.

Name of child _____ ☐ Boy ☐ Girl

Postal address _____

_____

Email address _____

Date of birth _____ NHI No. _____

Home phone _____

Parent/caregiver's name _____

Alternative name and contact number _____

_____

School area *(for dental appointments)* _____

GP's name _____

Ethnic origin - please tick which applies: *(this information is required for health statistics)*

☐ Māori ☐ NZ European ☐ Pacific Island ☐ Other

Print your name _____ **Date** _____

Signature _____

'Brush twice a day with a fluoride toothpaste'

wdhb.org.nz

P | Preschool Oral Health Facilitator | **06 348 8962** | **teeth@wdhb.org.nz**

A | Upstairs, Te Whare Kākāriki Building, Whanganui Hospital, 100 Heads Road, Private Bag 3003, Whanganui 4540

Better health and independence
He hauora pai ake, he rangatiratanga