



Referral to Dr James Millar – Orthodontist
BSc, BDS, DClinDent(Orth), MRACDS(Orth)

Patient's name: _____ DOB: _____

Parent's names (if under 18yrs): _____

Address: _____

Phone: _____ Email: _____

Reasons for referral / special comments: _____

Are there any radiographs attached? (These will be copied and returned) Yes / No

If so, please state which: _____

Referrer's name: _____ Date: _____

Practice: _____ Email: _____

Thank you so much for your referral. Please ensure you have provided an email address so that we can get in touch after seeing your patient. Please either post or, preferably, scan and email this form to us at the addresses below. Thank you 😊