



Dr Zeb McNamara

MBBS BSc BPharm FRACDS (OMS)
ORAL, DENTAL IMPLANT & MAXILLOFACIAL SURGEON

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PATIENT DETAILS:

First Name: _____ Last Name: _____ Date of Birth: ____ / ____ / ____

Patient Email: _____ Phone No.: _____

Patient Address: _____

_____ Postcode: _____

PRIMARY REASON FOR REFERRAL: Urgent Referral Routine Referral

Dentoalveolar

Referral details:

Implant/s

Oral Pathology

Orthognathic

TMJ

External Imaging Ordered? Type of Imaging? Radiology Company Name: _____

Yes No

OPG CT/MRI

REFERRING DOCTOR/DENTIST:

Name: _____

Practice Name: _____

Practice Address: _____

_____ Postcode: _____

Practice Email: _____ Phone No.: _____

Signature:

Provider No: _____

Date of Referral: ____ / ____ / ____

Contact Details:

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Practice Locations:

Brisbane City
Brookwater
Caboolture
Chermside
Greenslopes
Mt Gravatt
Newstead

Surgery Locations:

Brisbane Day Hospital
Caboolture Private Hospital
Greenslopes Private Hospital
Mater Private Hospital - Springfield
North West Private Hospital
Southbank Day Hospital
St Andrew's Private Hospital - Ipswich