



**DENTALWELLNESS
CENTRE**

**MEADOWBANK SHOPPING
CENTRE, SUITE 12
35 ST JOHNS ROAD
MEADOWBANK, AUCKLAND**



info@dentalwellnesscentre.co.nz

www.dentalwellnesscentre.co.nz



[\(09\) 975 0333](tel:(09)9750333)

DR JOANNA NGO

BDS (SINGAPORE) DCLINDENT (OTAGO)

SPECIAL CARE DENTAL SPECIALIST

SERVICES

Specialised Dental Care For People with:

Special Needs

Complex Medical Comorbidities

Physical Disabilities

Cognitive Issues

DENTAL TREATMENTS

EXAMINATION

ORAL HOMECARE TRAINING

DESENSITISATION VISITS

SCALING & POLISHING

FILLINGS

EXTRACTIONS

DENTURES

CROWNS AND BRIDGES

IMPLANTS



Patient Details

Name _____

DOB _____

Phone _____

Residential arrangement: Home/Residential care/Rest home

Address _____

Welfare guardian/ Next of kin contact _____

Best time for appointment _____

Referring Medical Specialist/General Practitioner/Dentist _____

Practice Contact Details _____

Medical History

Conditions:

Medications: (Please attach list)

Medications that increase bleeding risks: Warfarin/Aspirin/Rivaroxaban/Dabigatran/Clexane/Clopidogrel/Others: _____

Immunosuppressive medications: Prednisolone/Infliximab/Etanercept/Adalimumab/Others: _____

Bisphosphonates treatment: Alendronate/Etidronate/Risedronate/Zoledronate/Others: _____

Bisphosphonates treatment for Osteoporosis/Cancer in the form of Oral/IV

Date of commencement _____ Number of doses _____ Date of last dose _____

Latest hospital visits and discharge summary (Please attach)





Reason for referral (Please tick appropriate box, circle relevant condition and elaborate in spaces)

Special Needs: Autism/Down Syndrome/Cerebral Palsy/Global Developmental Delay/Others:

Cognitive issues: _____

Physical Disability: Speech impairment/Visual impairment /Hearing impairment / Wheelchair – able to transfer Y/N?

Medical conditions

Stroke: Date _____ Type _____ Areas affected _____

Dementia: Early/Mod/Late stage _____ Type _____

Parkinson's Disease: Early/Mod/Late stage _____ Type _____

Cardiac condition: Ischaemic heart disease/Heart failure/Rheumatic valve disease/Congenital heart disease/Others:

Oncology:

Type of cancer _____ Date of diagnosis _____

Chemotherapy drug types _____

Date commenced _____ Number of cycles _____ Date of next cycle _____ Date completed _____

Radiation treatment: Head and Neck / Other areas: _____

Date commenced _____ Date completed _____

Name and contact of Medical Specialist: _____

Dental Concerns:

☐ Poor Oral Hygiene

☐ Pain

☐ Dental Caries

☐ Loose tooth

Others: _____

Comments:

