backwell dental care

REFERRAL FORM FOR CBCT SCAN, OPG & CEPHALOMETRIC RADIOGRAPHS

SECTION 1- PATIENTS DETAILS:

Title:

First Name:

Surname:

Date of Birth:

Address:

Postcode:

Contact Telephone and email:

Medical history and medications

SECTION 2- DETAILS OF REFERRER

Name of Referrer:

Practice Stamp or Address:

Signature:

Date:

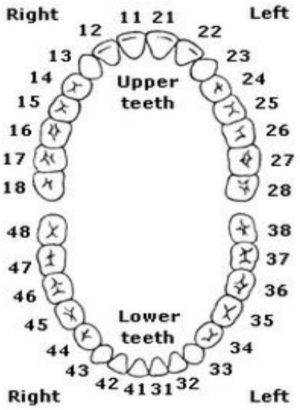
SECTION 3- DETAILS OF SERVICE REQUIRED (PLEASE TICK)

CBCT Scan* ☐

Comments:

*In order to keep the dose and exposure as low as reasonably practicable in compliance with IRMER, please note we will ONLY provide you with a scan showing the relevant position(s) of the selected teeth. Please specify if you require a larger CBCT scan and the reason why.
(For example, if you require a FULL UPPER CBCT scan in order to produce a Guide for a patient having only 1 implant in the upper)

Notation of tooth/position to be scanned:



OPG ☐

Please note the OPG machine is upstairs. Ensure patient able to be seen on first floor.