IMAGING REFERRAL FORM

REFERRING CLINICIAN

Date of Referral

Practice Name

Clinician Name

Address

Postcode

Email (Required)

PATIENT DETAILS

Title

First Name

Surname

Date of Birth

Contact number(s)

Email (Required)

IMAGING TYPE

Indicate Imaging Service required - please tick

◯ CBCT ◯ DPT ◯ IO-RAD ◯ DIOS ◯ DSLR

ADDITIONAL CLINICAL INFORMATION – CBCT, DPT & IO-RAD

Indicate regions of interest - please tick

◯ MAXILLA ◯ Right Lateral ◯ Anterior sextant - inter sinus ◯ Left Lateral

◯ MANDIBLE ◯ Right Lateral ◯ Anterior sextant - inter sinus ◯ Left Lateral

CLINICAL JUSTIFICATIONS

If images are to support treatment planning of dental implants please indicate justification

◯ MAXILLA
- ◯ Confirm shape of residual alveolus
- ◯ Confirm descent of nasal/maxillary minus prior to implant placement

◯ MANDIBLE
- ◯ Confirm shape of residual alveolus
- ◯ Confirm position of mandibular canal/metal foraman prior to implant placement

If images are to support Endodontic or surgical procedures please define primary area of interest

Consultant maxillofacial radiologist report required? (Additional fee of £85) ◯ YES ◯ NO

COMMENTS / ATTACHMENTS

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