savernake DENTAL

REFERRAL FORM FOR CBCT SCAN, OPG & CEPHALOMETRIC RADIOGRAPHS

Section 1 Patients Details	
Title	
Full name	
Date of Birth	
Address/Postcode	
Contact Telephone	

Section 2 Details of Referrer	
Name of Referrer	
Practice Stamp or Address	
Signature	
Date	

Reason For Scan	

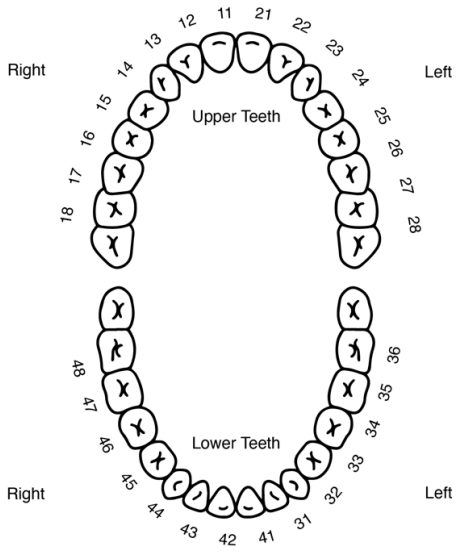
Section 3 Details of Service Required (Please Tick)

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 ☐

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