Dental Imaging Referral Form

1. Referred By: ______________________

*Required fields

PracticeName:* ______________________

Address:* ______________________

______________________ Postcode: __________

Telephone:* ______________ Email:* ______________

PatientName:* ______________________ D.o.B: _____/_____/_____

Address:* ______________________

______________________ Postcode: __________

Telephone:* ______________ Email:* ______________

Possibility of Pregnancy: Yes ☐ No ☐

2. Examination Required

2a. CBCT ☐ Mandible ☐ Maxilla ☐ Both Jaws ☐

Patient will wear a stent: Yes ☐ No ☐

Area of Interest:

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

PurposeofScan(e.g.ImplantPlanning): ______________________

Software Option

CT Viewer ☐ DICOM File ☐ SimPlant One Shot ☐ SimPlant Planner ☐ SimPlant Pro ☐

2b. 2–D Panoramic ☐

3. Delivery Options CD ☐ DropBox + Email ☐ Photo Paper ☐

4. Radiologists Report

IRMER 2000 Regulations: To comply with these regulations all radiographs and CBCT scans are to be reviewed and reported on. All relevant findings are to be recorded in the clinical notes. This is the sole responsibility of the referring clinician. We can however arrange for a radiologist report.

Yes, please arrange a radiologist report ☐ No, I do not require a radiologist report ☐

5. Payment Invoice referring clinician ☐ Patient to pay ☐

6. Justification Signature ______________ GDC No: __________ Date: _____/_____/_____

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Your Partner in Periodontal Care