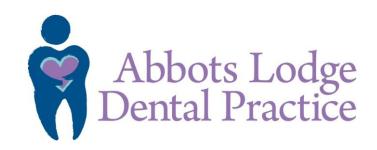


## **CBCT & OPG REFERRAL FORM**

Name:  OPG  Mandible – Lower Jaw  CBCT  Mandible – Upper Jaw  Practice Name:  OPG/OPT  Both Jaws  Postcode:  Email:  Telephone:  Patient Details  Patient Name  Male / Female  Pregnant  DOB  Address  Post Code  Contact No's.  Patient Signature  Date of referral  Date of scan  Scan sent Date  Signature of performer  GDC No.	Referring Dentist Details	Scan r Details	request	Area – Sectional Quadr	ant
Practice Name:  OPG/OPT  Both Jaws  Postcode:  Email: Telephone:  Patient Details Patient Name  Male / Female Pregnant DOB Address  Post Code Contact No's. Patient Signature Date of referral Date of scan Scan sent Date  Signature of performer	Name:	OPG		Mandible – Lower Jaw	
Postcode:  Email: Telephone:  Patient Details Patient Name  Male / Female Pregnant DOB Address  Post Code Contact No's. Patient Signature Date of referral Date of scan Scan sent Date Signature of performer	GDC No:	CBCT		Mandible – Upper Jaw	
Email: Telephone:  Patient Details Patient Name  Male / Female Pregnant DOB Address  Post Code Contact No's. Patient Signature Date of referral Date of scan Scan sent Date Signature of performer	Practice Name:	OPG/0	OPT	Both Jaws	
Patient Details Patient Name  Male / Female Pregnant DOB Address  Post Code Contact No's. Patient Signature Date of referral Date of scan Scan sent Date  Comments/Notes  Comments/Notes  Address	Postcode:				
Patient Details Patient Name  Male / Female Pregnant DOB Address  Post Code Contact No's. Patient Signature Date of referral Date of scan Scan sent Date  Signature of performer	Email:				
Patient Name  Male / Female Pregnant  DOB  Address  Post Code Contact No's.  Patient Signature Date of referral Date of scan Scan sent Date  Signature of performer	Telephone:				
Patient Name  Male / Female Pregnant  DOB  Address  Post Code Contact No's.  Patient Signature Date of referral Date of scan Scan sent Date  Signature of performer					
Male / Female  Pregnant  DOB  Address  Post Code  Contact No's.  Patient Signature  Date of referral  Date of scan  Scan sent Date  Signature of performer	Patient Details			Comments/Notes	
Pregnant  DOB  Address  Post Code  Contact No's.  Patient Signature  Date of referral  Date of scan  Scan sent Date  Signature of performer	Patient Name				
DOB Address  Post Code Contact No's. Patient Signature Date of referral Date of scan Scan sent Date Signature of performer	Male / Female				
Post Code Contact No's. Patient Signature Date of referral Date of scan Scan sent Date Signature of performer	Pregnant				
Post Code Contact No's. Patient Signature Date of referral Date of scan Scan sent Date Signature of performer	DOB				
Contact No's.  Patient Signature  Date of referral  Date of scan  Scan sent Date  Signature of performer	Address				
Contact No's.  Patient Signature  Date of referral  Date of scan  Scan sent Date  Signature of performer					
Patient Signature  Date of referral  Date of scan  Scan sent Date  Signature of performer	Post Code				
Date of referral  Date of scan  Scan sent Date  Signature of performer	Contact No's.				
Date of scan Scan sent Date Signature of performer	Patient Signature				
Scan sent Date Signature of performer	Date of referral				
Signature of performer	Date of scan				
	Scan sent Date				
	Signature of performer				
	GDC No.				



Scan Details	Cone Beam CT	OPT/OPG	
Type of scan			
Scan Template to be fitted	Yes	No	
Justification for Scan			

Scan Size (please indicate area on Diagram)

Sectional

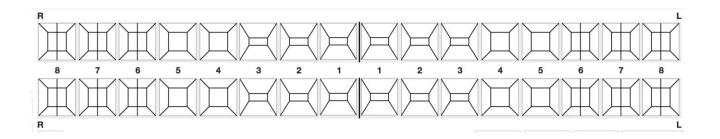
Quadrant

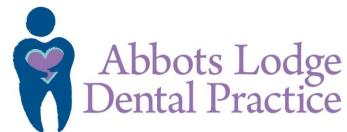
Mandible (Lower Jaw)

Mandible (Upper Jaw)

**Both Jaws** 

(If no teeth specified, full jaw will be scanned





Referring Dentist	Signature:	Date:	Practice Acceptance Y/N
Print Name			