riverdental

Referral form for CBCT Scan, OPG & Cephalometric Radiographs

Section 1- Patients Details:

Title:

First Name:

Surname:

Date of Birth:

Address:

Postcode:

Contact Telephone:

Section 2- Details of Referrer

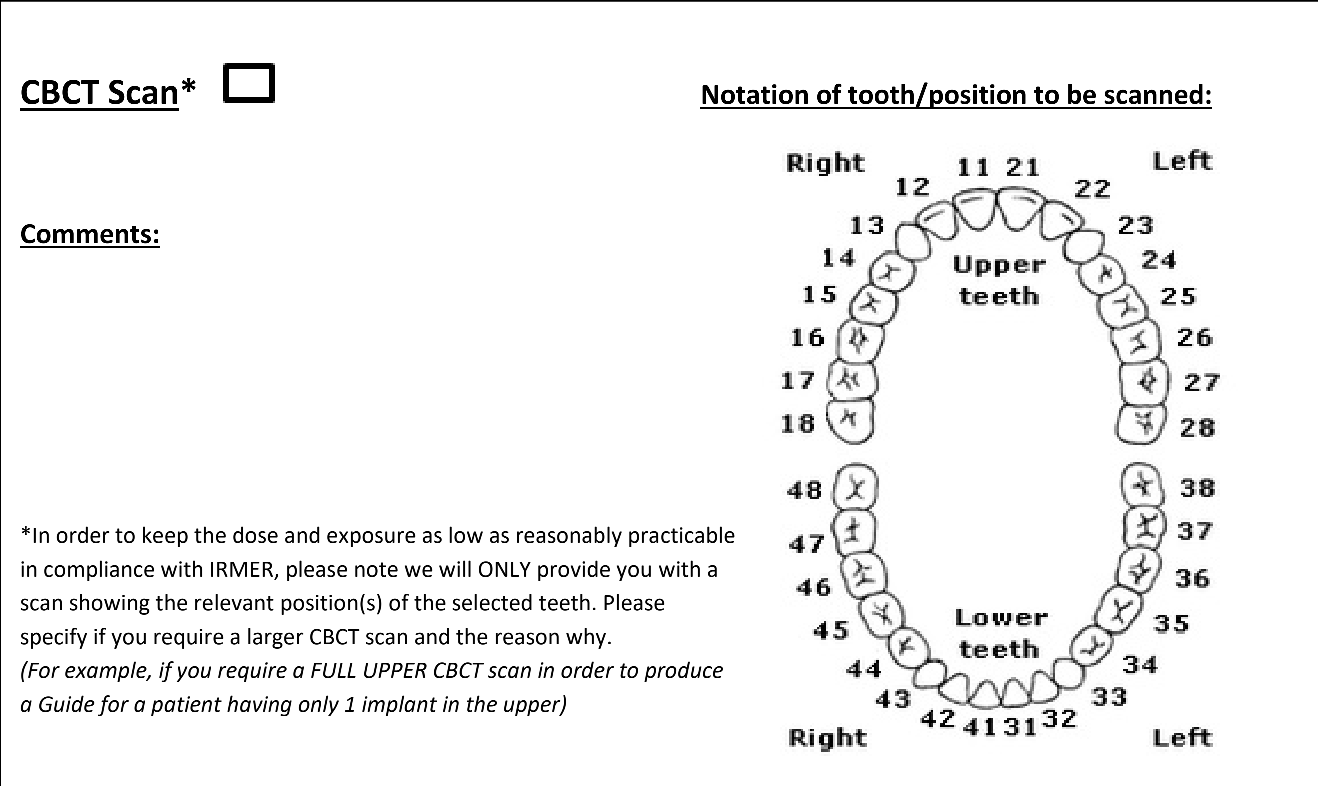
Name of Referrer:

Practice Stamp or Address:

Signature:

Date:

Section 3- Details of service required (please tick)



CBCT Scan* ☐

Notation of tooth/position to be scanned:

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)

OPG ☐

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