X-Ray & CBCT Scan Referral Form

PATIENT DETAILS

NAME

ADDRESS

TEL D/O/B

POSSIBILITY OF PREGNANCY? YES ☐ NO ☐

REFERRING PRACTITIONER'S DETAILS

NAME

ADDRESS

TEL EMAIL

DATE SIGNATURE

PAYMENT: PATIENT TO PAY ☐ ACCOUNT TO REFERRER ☐

EXAMINATION REQUIRED

DIGITAL OPG X-RAY ☐ DIGITAL CEPHALOMETRIC X-RAY ☐

CONE BEAM CT ☐ MY PATIENT WILL WEAR A STENT ☐

PURPOSE (mandatory):

REGION OF INTEREST FOR CT SCAN

UPPER JAW ☐

LOWER JAW ☐

SMALL VOLUME ☐
(use tooth diagram)

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

If no teeth are selected, the whole jaw will be scanned

DELIVERY OPTIONS

EMAIL ☐ If email please write your address here

NOTES

IMER 2000 Regulations: The Dental Gallery does not routinely report upon scans or radiographs. To comply with the IRMER 2000 Regulations all radiographs and scans are required to be reviewed and reported into the clinical notes by the referring practitioner or by a radiologist. The Dental Gallery strongly recommends that all CT and other radiographic examinations should be reported upon to rule out the possibility of coincidental pathology.

The Dental Gallery 3 The Mall Ealing London W5 2PJ
T 020 8566 3194 E info@thedentalgallery.co.uk W www.thedentalgallery.co.uk