alliance DENTISTRY

CBCT / OPG Referral Form

Patient

Name _____

Date of Birth _____

Address _____

_____

_____

_____

Home Phone _____

Mobile Phone _____

Referrer

Name _____

Address _____

_____

_____

_____

Email _____

Phone _____

Signature _____

Scan Requested

☐ OPG - Bitewings program ☐ Sectional OPG ☐ Full OPG

☐ 5x5cm CBCT (sectional) ☐ 8x5cm CBCT (half mouth) ☐ 8x8cm CBCT (full mouth)

Clinical context for requesting CBCT / OPG examination

_____

Relevant results of history, clinical examination and other imaging

_____

What information do you want the CBCT / OPG examination to provide?

_____

Define the anatomical area that the scan(s) should cover

_____

Internal Use

Justification

IRMER Practitioner: _____

Signature: _____

Date _____

Scan authorised _____

Scan information:

Operator: _____

Signature: _____

Date of scan: _____

Exposure: _____

Clinical evaluation (Reporting)* - please continue overleaf if required.

_____

_____

_____

_____

Outcome: _____

Signature: _____

Name of Operator (Reporting): _____ Date _____

* If, under the Service Level Agreement dental CBCT images will be reported on by the referring practice, this fact should be recorded here. The referring practice will then be responsible for ensuring the clinical evaluation takes place and is properly recorded.