

Referring Dentist details:

Practice name and address		
Post Code		Telephone:

Patient details:

Surname		First name	
Date of birth			
Residential address (including postcode)			
Phone number			

This section MUST be completed IN FULL by the referring dentist only

REASON FOR REFERRAL/JUSTIFICATION FOR REQUESTED IMAGE	implant planning : endodontics : orthodontics : oral surgery : Tmj : Other please specify :																																
Define the anatomical area that you would like the scan to cover The 3D scan volume is a cylinder with 50mmx50mm or 80mmx80mm Please circle the area(s) to be scanned	<table border="1" style="width: 100%; text-align: center;"> <tr> <td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> </tr> <tr> <td>8</td><td>7</td><td>6</td><td>5</td><td>4</td><td>3</td><td>2</td><td>1</td> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td> </tr> </table> <p>Please Tick OPG 2D : <input type="checkbox"/> Cone Beam Scan 5x5 for three or four tooth area in a single arch: <input type="checkbox"/> Cone Beam Scan 8x8 for both arches to include all teeth:</p>	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
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Referral authorised by: Dentist name, signature, Date:	I accept that I am responsible for the reporting of this image and it's appropriate management																																
Please tell us your preferences: Please tick: Patient to pay at visit <input type="checkbox"/> Invoice referring practice <input type="checkbox"/> Please tick: Patient to take image away with them <input type="checkbox"/> Send image to referring practice <input type="checkbox"/>																																	