Mile End Dental Clinic
13a Nayland Road
Colchester, CO4 5EG
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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	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 Please Tick OPG 2D : ž Cone Beam Scan 5x5 for three or four tooth area in a single arch: ž Cone Beam Scan 8x8 for both arches to include all teeth:
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** ☐ **Invoice referring practice** ☐

Please tick: Patient to take image away with them ☐ Send image to referring practice ☐

Please fax completed form to: 01206 835097
Scan and Email to: mansour.kangi@nhs.net
Post to: Mile end Dental Clinic 13A Nayland Road Colchester Essex CO45EG