THE DENTAL CENTRE
BEDFORD

Imaging Referral Form

Referring Dentist Details

Referring Dentist

Practice Name

Practice Address

Practice Phone Number

Reason for Scan

- ☐ Implants
- ☐ Ortho
- ☐ Impacted Teeth
- ☐ Endodontics
- ☐ Sinus Exam
- ☐ TMJ

Patient Details

Name

Tel:

Mobile:

email:

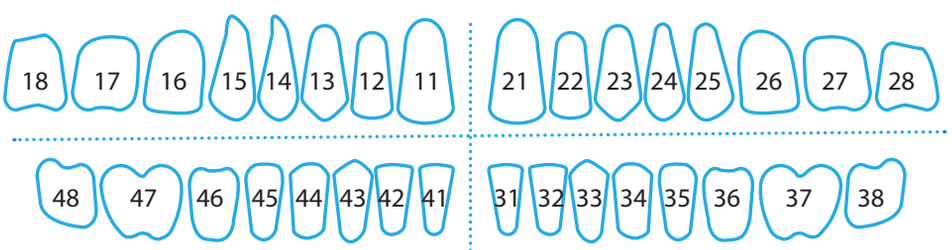
Date of Birth ☐☐ ☐☐ ☐☐
date month year

Relevant Medical History

Sinus Exam

Draw Area of Interest

☐ Dual Jaw ☐ Mandible ☐ Maxilla ☐ Small Field 5x5 ☐ True 2D OPG



Delivery of Scan

☐ USB Stick ☐ Cloud based/email

Reporting

To comply with IRMER 2000 regulations radiographs and CT scans should be reviewed by the referring practitioner or by a radiologist. This can rule out the possibility of coincidental pathology. We recommend this service and are happy to offer a report via a Consultant Radiologist.

Tick to indicate you are a trained referrer ☐

Tick to indicate. I would like this referral to be reported upon by a consultant radiologist. ☐

By not ticking this box I will take responsibility to make my own arrangements

Clinical Justification

Name of practitioner

Signature Date

The Meiklejohn Centre 5 Kingswood Way Bedford MK40 4GH 01234 819868