WEST PARADE
Dental Care

Digital CBCT/Imaging Referral Form

Please complete the patient details and either post or complete using our online form.

Service required

Right OPG ☐ Left OPG ☐ Full OPG ☐ CBCT Small FOV (50mm²) ☐

CBCT Full Scan (100 x 85mm) ☐ Do you require a report from a maxillofacial radiologist (additional fees apply) ☐

Referring practitioner's details

Name: ....

Address: ....

....

.... Postcode: ....

Tel: .... Email: ....

Patient details

Name: .... DOB: ....

Address: ....

....

.... Postcode: ....

Tel(home/work/mobile):.....................................Email:..

Reason for referral, clinical details

Urgent / Routine: ....

....

....

....

....

....

Date of referral

__ / __ / ____

Radiographs included: Yes / No

If yes, how many and are they to be returned? ....

....

How would you like us to keep you informed of the patient's treatment?

Email ☐ Post ☐

West Parade Dental Care | 33 West Parade | Lincoln LN1 1PE

T 01522 523821 **E** reception@westparadedentalcare.co.uk **W** westparadedentalcare.co.uk