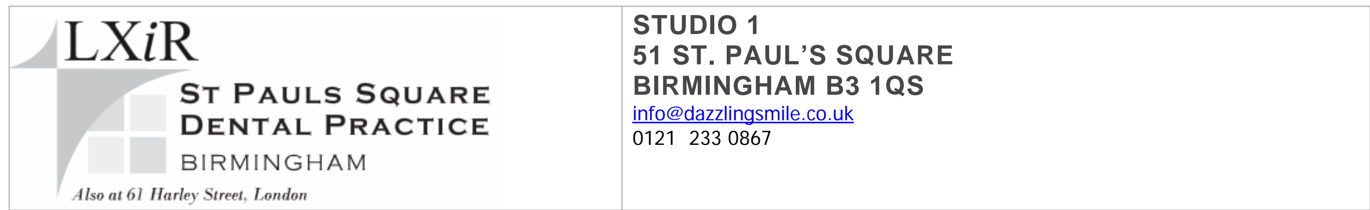
IMAGING REFERRAL FORM



STUDIO 1
51 ST. PAUL'S SQUARE
BIRMINGHAM B3 1QS
info@dazzlingsmile.co.uk
0121 233 0867

REFERRING DENTIST

NAME:		REFERRAL DATE:	
PRACTICE:			
ADDRESS:			
		TEL:	
POSTCODE:		E-MAIL:	

PATIENT INFORMATION

NAME:		DOB:	
ADDRESS:		TEL (HOME):	
		TEL (MOBILE):	
POSTCODE:		E-MAIL:	

RELEVANT MEDICAL HISTORY

(Please send a copy of medical history forms if available)

TYPE OF VIEW REQUIRED

2-D

☐ DIGITAL PANORAL
☐ DIGITAL LATERAL CEPHALOMETRIC

3-D

☐ UPPER JAW
☐ LOWER JAW
☐ SINUS
☐ ZYGOMA
☐ LEFT TMJ
☐ RIGHT TMJ
☐ SMALL VOLUME (PLEASE SPECIFY AREA OR TOOTH)

....

☐ **model required**

REGION OF INTERSEST AND PURPOSE OF EXAMINATION

PAYMENT AND DELIVERY

☐ **PATIENT TO PAY** ☐ **REFERRER TO PAY**

☐ **CD**
☐ **EMAIL**

Signed..date................

We do not routinely report upon scans and radiographs. To comply with the IRMER 2000 regulations all radiographs and scans are required to be reviewed and reported into the clinical notes by the referring practioner or by a radiologist. If you would like a radiologist to report on the image please request this ☐