Harbour Dental

EXTERNAL CBCT/OPG SCAN REFERRAL FORM

PATIENT DETAILS

TITLE: FORENAME:

DATE OF BIRTH: SURNAME:

ADDRESS:

POSTCODE:

MOBILE NUMBER: HOME NUMBER:

EMAIL ADDRESS:

RELEVANT MEDICAL HISTORY:

WHAT IS THE CLINICAL CONTEXT FOR REQUESTING A DENTAL CBCT SCAN OR OPG?

WHAT INFORMATION WOULD YOU LIKE THE DENTAL CBCT SCAN/OPG TO PROVIDE?

DEFINE THE ANATOMICAL AREA THAT THE SCAN SHOULD COVER:

REFFERER DETAILS

TITLE: FORENAME:

CONTACT NUMBER: SURNAME:

ADDRESS:

POSTCODE:

EMAIL ADDRESS:

23-25 CREWE ROAD, SANDBACH, CHESHIRE, CW11 4NE
INFO@HARBOURDENTALPRACTICE.CO.UK
01270 762 186

TO BE COMPLETED BY HARBOUR DENTAL PRACTICE

NAME OF REFERRER/PRACTITIONER:

DATE:

DETAILS OF SCAN AUTHORISED:

NAME: SIGNATURE:

SCAN INFORMATION

NAME OF OPERATOR:

DATE OF SCAN/OPG:

EXPOSURE FACTORS USED:

ON COMPLETION, PLEASE RETAIN THIS FORM AND RETURN A COPY TO THE REFERRING PRACTICE.