WEST PARADE
Dental Care

Digital CBCT/Imaging Referral Form

Please complete the patient details and either post or email: radiography.westparade@portmandental.co.uk

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: .....

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Date of referral

__ / __ / ____

Radiographs included: Yes / No

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

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

Email ☐ Post ☐