CBCT & OPG REFERRAL FORM

www.mkdentist.co.uk/cbct-and-opg-referral

Oxford House
THE REFERRAL CENTRE

DENTIST DETAILS AND DELIVERY ADDRESS

Name of Practitioner | Date

Practice Name

Practice Address

Postcode

Practice Phone Number | Mobile

Email

PATIENT DETAILS

Patient First Name | Surname

Patient Address

Postcode

Date of Birth

Mobile | Email

REFERRAL INFORMATION (Please tick all relevant boxes)

3D IMAGING

◯ CBCT Scan
(please update area of interest below)

Type of scan

◯ Full Mouth Scan (8x8cm)
◯ Mandible Only (8x5cm)
◯ Maxilla Only (8x5cm)
◯ Small Volume (5x5cm)

2D IMAGING

OPG

Payment

◯ Dentist/Practice ◯ Patient

How would you like to receive your CBCT?

◯ USB (+£10 Fee) ◯ Dropbox (Enter email)

Email

Is the patient coming with a radiographic template?

◯ Yes ◯ No

Is the patient possibly pregnant?

◯ Yes ◯ No

AREA OF INTEREST

☐ 18 ☐ 17 ☐ 16 ☐ 15 ☐ 14 ☐ 13 ☐ 12 ☐ 11 | ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28

☐ 48 ☐ 47 ☐ 46 ☐ 45 ☐ 44 ☐ 43 ☐ 42 ☐ 41 | ☐ 31 ☐ 32 ☐ 33 ☐ 34 ☐ 35 ☐ 36 ☐ 37 ☐ 38

JUSTIFICATION FOR X-RAY

◯ Bone Graft
◯ Implants
◯ Endodontics
◯ Impacted Teeth
◯ Sinus Exam
◯ TMJ
◯ Oral Pathology
◯ Orthodontics
◯ Other (please state)

EXTRAS

◯ Extra Copy (An additional fee will apply)

CLINICAL INDICATIONS (MANDATORY)

Full Radiologist report by Dr Jimmy Makdissi £110(please allow 5-10 working days)

◯ Yes ◯ No

SUBMITTED BY

Name | Date

Email

◯ Please tick to consent to be kept informed of lectures, events and allow us to email articles.