Referral form CT scan (CBCT) x-ray IR(ME)R
Accepting referrals from another Dental Practice
Authorisation

Patients name Surname _____

First Name _____

Date of Birth __/__/__

Address _____
_____
_____
_____

Patient Tel No: _____

Area of interest:-
X-ray Examination Request, Circle: Maxilla, Mandible, Maxillary Sinuses, Others
_____
_____
_____

Justification (Reason for CT Scan)
Clinical information relevant to the Dental exposure requested
_____
_____
_____

Signatures of referring Dentist _____ Referral Date __/__/__

And I as the referring dentist for the x-ray am dependent on myself in providing and recording a competent clinical evaluation on all images returned to me and I confirm that I have gained the necessary knowledge to do so.
Dr Mc Kenna will return a record of dosage and exposure time
Print Name or stamp of referring Dentist