HIGHCLIFFE DENTAL CARE

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Tel: 01425 277770

REFERAL FORM

REFERRING DENTIST

Title ____ Name _____

Address _____

_____

Post Code _____ Telephone _____

PATIENT DETAILS

Title ___ Full Name (Please print) _____

DOB _____Address_____

_____

Telephone Number Home _____

Mobile Telephone Number _____

PURPOSE OF PREFERRAL

Consultation for Implant Placement ☐

CBCT Scan ☐

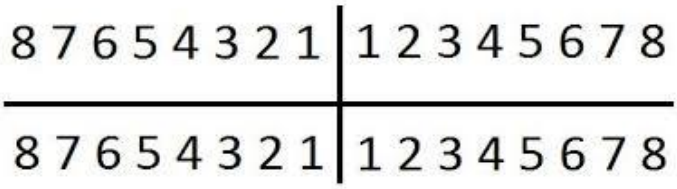
REASON FOR REFERRAL/DIAGNOSIS

Examination required:

☐ Cone Beam CT ☐ OPG ☐ Patient will wear a stent

Region of interest:

☐ Upper Jaw ☐ Lower Jaw ☐ TMJ ☐ Small volume indicate on diagram



Please tick as appropriate:

☐ I would like the study to be reported by a Consultant Radiologist

☐ I will make alternative reporting arrangements

DATE: SIGNATURE REFERRING DENTIST: