

GIPSY LANE  
ADVANCED DENTAL CARE

CLINICAL REQUEST FORM FOR DENTAL CT SCAN / OPG

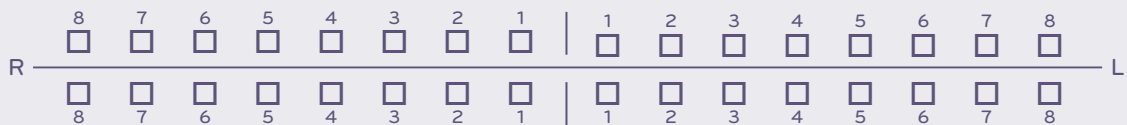
Patient Details (Please use BLOCK capitals)

Mr  Mrs  Ms  Other  \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Telephone: \_\_\_\_\_  
Surname: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
Forename(s): \_\_\_\_\_ Mobile: \_\_\_\_\_  
Address: \_\_\_\_\_ E-mail: \_\_\_\_\_  
Postcode: \_\_\_\_\_ Possibility of pregnancy: Yes / No

Examination Required (Please tick ✓)

CT MAXILLA  CT MANDIBLE  BOTH  OPG

All images will be taken parallel to the occlusal plane unless you specify a different orientation here:



It is an IR(ME)R requirement that the Referrer provides sufficient clinical information for the x-ray procedure to be justified. Please provide a brief clinical history and state the questions that the OPG or CBCT examination is designed to answer.

Patient to wear stent provided by dentist: Yes / No

All CBCT's will be sent with Invivo Dental Viewer and DICOM images put on to a disc clearly labelled with the patients name and the area scanned.

It is an IR(ME)R requirement that the images must be clinically evaluated and the findings recorded in the patient's notes. Please state who will be doing this:

Referrer Details (\*Must be completed)

Signature\*: \_\_\_\_\_ Print Name\*: \_\_\_\_\_  
Contact Details: \_\_\_\_\_  
Referrer E-mail: \_\_\_\_\_ Referrer Tel No: \_\_\_\_\_

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