Dental Cone Beam CT Imaging Referal Form

TO BE COMPLETED BY THE REFERRER

PATIENT DETAILS

Name:

Date of Birth: dd:mm:yyyy

Contact Telephone No: Daytime:

Mobile:

Address:

Email Address:

IRMER REFERRER DETAILS

Name:

Date of Referal: dd:mm:yyyy

Contact Telephone No: Daytime:

Address:

Email Address:

The clinical context for requesting a dental CBCT examination:

What information do you want the dental CBCT examination to provide?

Define the anatomical area that the scan should cover?

ON COMPLETION: Please email this form to reception@premierdentalclinic.co.uk or post to - Premier Dental Clinic, 77 Beckenham Lane, Shortlands, Bromley, Kent BR2 0DN. If you have any problems or questions filling out this form please call us on 0208 460 9150.