CBCT Refferal Form

IRMADENT

REFERRER DETAILS

Name of Referrer:
Practice Name:
Address:
Telephone:
Email:

PATIENT DETAILS

Name of Patient:
Date of Birth:
Address:
Telephone:
Email:

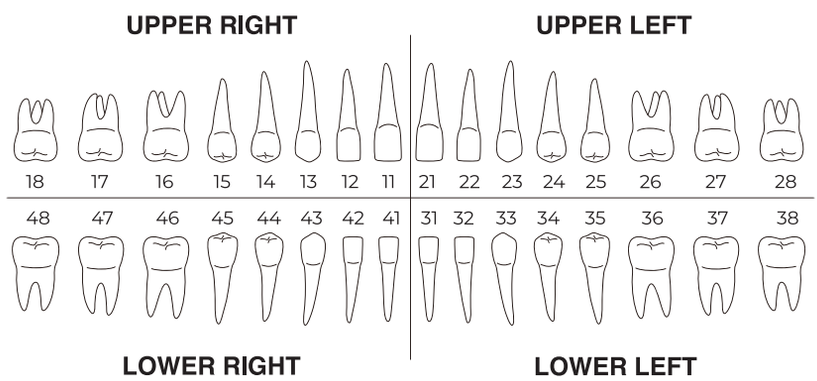
CLINICAL INDICATIONS (Please complete):

Referrer Signature:

JUSTIFICATIONS FOR X-RAYS:

- ☐ Digital Panoramic
- ☐ Implants
- ☐ Bone Graft
- ☐ Impacted Teeth
- ☐ Endodontics
- ☐ Sinus Exam
- ☐ TMJ
- ☐ Oral Pathology
- ☐ Ortho

☐ **Mandible** ☐ **Maxilla** ☐ **Both Jaws**



Is the patient coming with Radiographic Sent ☐ Yes ☐ No

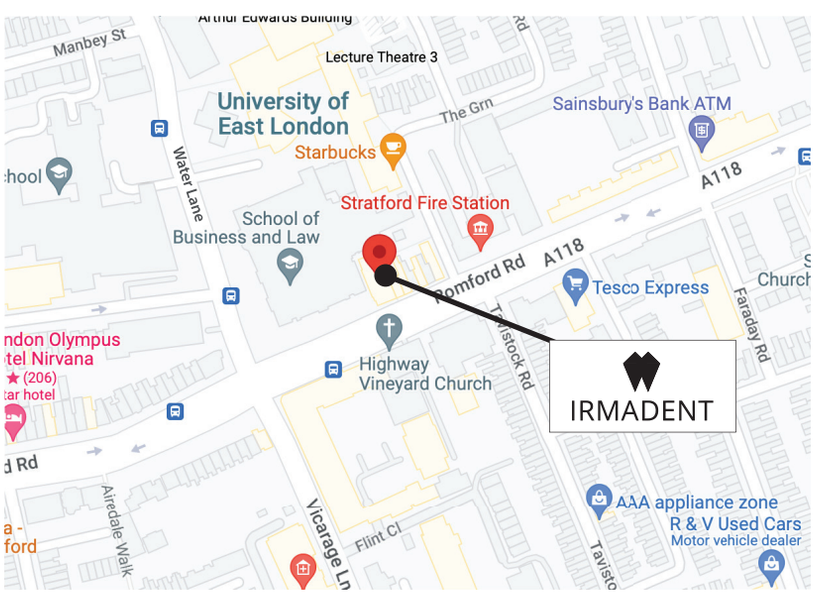
Is the patient possibly pregnant? ☐ Yes ☐ No

File delivery options:

☐ To Patient ☐ To Referrer

☐ Email ☐ USB Stick ☐ WeTransfer

Imadent private dental & aesthetic clinic do not routinely report on CBCT scans. To comply with the IRMER 2000 regulations all CBCT scans are required to be reviewed and reported in the clinical notes by the referring practitioner or by a radiologist.



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