Digital Panoramic X-Ray Referral Form

Patient Details

Forename: _____ Surname: _____

D.O.B _____ Phone No. _____

Address: _____

_____

Email: _____

Referring Dentist

Forename: _____ Surname: _____

Phone No. _____ Email: _____

Clinic Address: _____

_____

Dentists Signature: _____ Date: _____

Referral Date: _____ Image Required: DPT

Prosthesis? _____

Reason for requesting CT scan (justification required under IRME 2000)

TwentyOneDental Use			
Authorised By			
Signed		Date	
Justification			
Taken By			
Signed		Date	

Please note that it is the responsibility of the referring practitioner to evaluate and report on the radiograph.

The digital x-ray is supplied as an attachment to an email as a jpeg or dicom image.

If you require a hard copy (CD) please tick here ☐