ENDOCLINIC

practice limited to endodontics

IMAGING REFERRAL

Referring Practitioner

Name: .....

Address: .....

.....

Tel: .....

Patient Details

Name: .....

Address: .....

.....

DOB: .....

Tel (M): ..... (W): .....

(H): .....

Type of imaging required including region of interest

☐ OPG

☐ Small Volume CBCT

☐ Large Volume CBCT

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

☐ Maxilla (upper jaw)

☐ Mandible (lower jaw)

☐ Both Jaws (Maxilla and Mandible)

Purpose of examination (mandatory) .....

Radiologist Report

☐ Yes please provide a radiologist report on the patients's radiographic examination

☐ No I will make my own arrangements for reporting on the image/s

Payment to be be paid by the patient on the day of imaging.

Signed: ..... Date: .....

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