ENDOCLINIC

practice limited to endodontics

REFERRAL FORM FOR IMAGING

Referring Practitioner

Name:.....

Address: .....

.....

Tel: .....

Patient Details

Name:.....

Address: .....

.....

DOB:.....

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

(H): .....

Referral Information for Imaging

Type of imaging required

Digital Panoramic ☐ Cone Beam CT ☐

Region of Interest & Purpose of Examination (mandatory)

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

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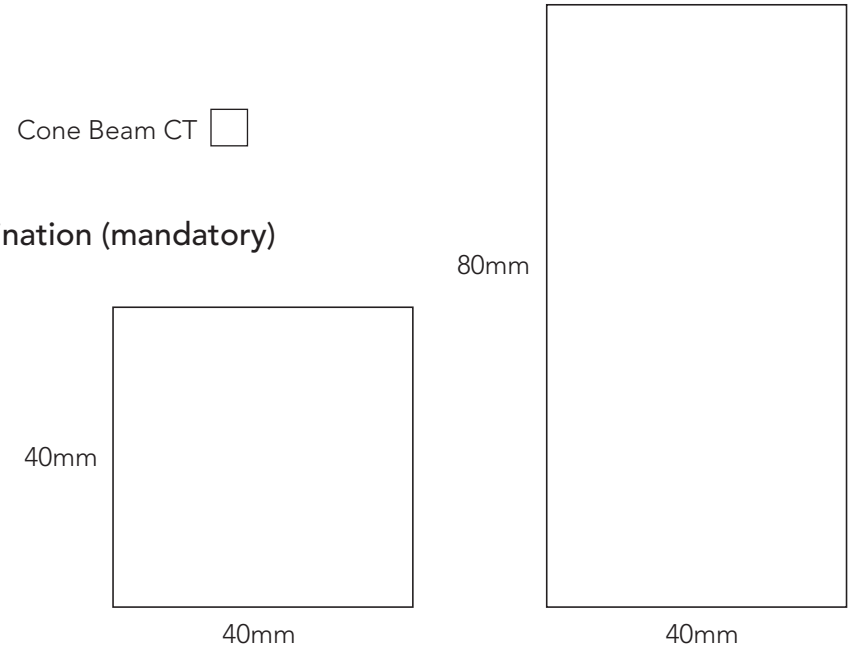

☐ Yes please provide a radiologist report on the patients's radiographic examination

☐ 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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