

OPG Referral Form

REFERRING DENTIST DETAILS & DELIVERY ADDRESS

Name of referring clinician:

Address of referring clinician:

Practice name:

Telephone:

Practice email:

PATIENT DETAILS

Appointment Date: / / Time:

Patients Name:

Address:

Date of Birth: / /

Phone: Mobile:

Email:

CBCT OUTPUT
AREA OF INTEREST CBCT ONLY

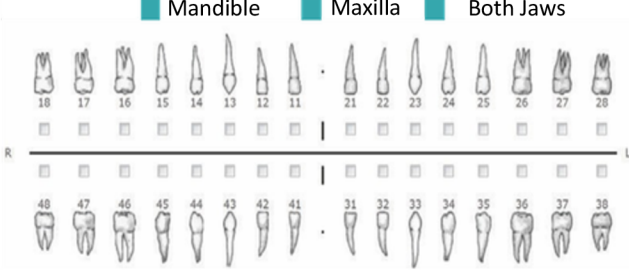
2D IMAGING 2D OUTPUT

DVD Dropbox Planmeca Cloud

Digital Panoramic (OPG) DVD
 Dropbox Planmeca Cloud

PAYMENT Dentist Patient

Mandible Maxilla Both Jaws



(If no teeth are selected the whole jaw will be scanned)

Is the patient coming with a radiographic template? Yes No

Is the patient possibly pregnant? Yes No

CBCT FORMAT	JUSTIFICATION FOR X-RAY	EXTRAS
DICOM Files Romexis Viewer	Implants Bone Graft	Additional copy
	Impacted Teeth	
(MAC OS and windows)	Endodontics	
	Sinus Exam	
	TMJ	
	Oral Pathology	
	Ortho	

CLINICAL INDICATIONS (mandatory)

Large empty box for clinical indications.

I confirm that as an "operator", in terms of interpreting images I am adequately trained in this task and accept responsibility for reporting and treatment planning.

REFERRING CLINICIAN:

Signature: Date:

PATIENT: Signature: Date: