

Referral Form

DENTAL MEDICAL IMAGING

online booking is available on our website:
www.bracelands.co.uk/croydon/cbct-scanner-referrals

PRACTITIONER DETAILS & DELIVERY ADDRESS

Name of Practitioner:

Practice name:

Address:

Telephone:

Email:

PATIENT DETAILS

Appointment Date: / / **Time:**

Forename & Surname:

DOB: / /

Telephone:

PAYMENT Doctor Patient

CBCT

Mandible Maxilla Both Jaws

Is the patient coming with a radiographic stent? Yes No

Is the patient possibly pregnant? Yes No

2D IMAGING

Digital Panoramic (OPG) Ceph Tracing Report

Digital Cephalometric

3D IMAGING

Full CBCT Scan

EXTRAS

Pathology Report Extra Copy

Radiology Report

Please select your preferred CBCT format:

DICOM Files STL

CLINICAL INDICATIONS (Mandatory)

Signature