**REFERRAL FORM Please TICK**

**OPG**

**CBCT**

**REFERRING DENTIST DETAILS**

Full Name: ………………………………………………………………………….... Date Referred: ………….……………………….….

Address: ……………………………………………………………………………………………………………………..…….……………………….……...

…………………………………………….…………………..…………………………… Postcode: ………………………………………...…..

Telephone: ……………………………………..………….. E-mail: …………………………………………...…………………...…………..

**PATIENT DETAILS**

Patient’s Name: ……………………………………………………………..…….. Date of Birth: …………………...……..……..…….

Patient’s Address: ……………………………………………………………………………………..…...…………….………………………..………...

…………………………………………….…………………..…………………………… Postcode: ………………………………………...…..

Home Tel: …………………………………………………… Work Tel: ………………...………………………………………………..…….

Mobile Tel: …………………………….…………...……… E-mail: …………………………………………...…………………...…………..

**CBCT/OPT REFERRALS:**

 **CBCT Digital Panoramic**

Maxilla Mandible Sinus

**FIELD OF VIEW (cm):**

 12 x 8.5 8.5 x 8.5 8.5 x 5 5 x 5

**Patient to wear Radiographic Marker?**

 Yes No

**CBCT SCANS WILL BE DELIVERED BY CD IN POST**

Please make your own External Radiology Reporting arrangements should you require them.

**IMPLANT REFERRALS:** Assessment Advice

 Problems & Diagnosis Surgical Placement Only

Surgical Placement & Restoration

Augmentation & Surgical Placement

**OTHER REFERRALS AVAILABLE:**

 SEDATION SPECIALIST ENDODONTIST

 SURGICAL SPECIALIST PERIODONTIST

 DENTURE ORTHODONTIC

**REASON FOR REFERRAL** (incl. region of interest and purpose of examination, continue overleaf if necessary):

................................................................................................................................................................................

................................................................................................................................................................................

................................................................................................................................................................................

................................................................................................................................................................................

................................................................................................................................................................................

................................................................................................................................................................................

**Once completed, please EMAIL to**

reception@heraldswaydental.com

**Please POST the original signed form to:**

**Heralds Way Dental Clinic**

**2 Heralds Way, South Woodham Ferrers, Essex CM3 5TQ/ Tel: 01285 640248**