Radiology Referral Form

1. Referred By: _____

Practice Name: * _____ * Required fields

Address: * _____

_____ Eircode: _____

Telephone: * _____ Email: * _____

Patient Name: * _____ D.o.B: ___ / ___ / ___

Address: * _____

_____ Eircode: _____

Telephone: * _____ Email: * _____

Possibility of Pregnancy: Yes ☐ No ☐

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2. Examination Required

Area of interest:

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

2a. CBCT ☐ Mandible ☐ Maxilla ☐ Both Jaws ☐

Patient will wear a stent: Yes ☐ No ☐

Purpose of Scan (e.g: Implant Planning): _____

Software Option

CT Viewer ☐ DICOM ☐ Additional fees will apply

2b. 2–D Panoramic ☐

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3. Delivery Options (tick one only) CD ☐ Email ☐ Photo Paper ☐

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4. Radiologists Report

To comply with Radiology regulations all radiographs and CBCT scans are to be reviewed and reported on. All relevant findings are to be recorded in the clinical notes. This is the sole responsibility of the referring clinician. We can however arrange for a radiologist report.

Yes, please arrange a radiologist report ☐ No, I do not require a radiologist report ☐

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5. Payment Invoice referring clinician ☐ Patient to pay ☐

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6. Justification: Signature: _____ GDC No: _____ D.o.B: ___ / ___ / ___

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