DentalBees
WE WORK HARD FOR YOUR SMILES

Referral Form

Date of examination: .....

Referred by name: .....

Referred by address: .....

.....

.....

Referred by phone number: .....

Referred by email address: .....

GDC Number: .....

Patient Title: .....

Patient Name: .....

Patient home telephone number: .....

Patient mobile number: .....

Patient address: .....

.....

Patient date of birth: .....

Possibility of pregnancy: Yes/No

Patient relevant medical history: .....

.....

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Payment

☐ Account to referrer ☐ Patient to pay

Examination required

☐ Digital Panoramic ☐ Cone Beam CT Parallel to occlusal plane/lower border/palate

My patient will wear a stent? Yes/No

UR	1	2	3	4	5	6	7	8
UL	1	2	3	4	5	6	7	8
LR	1	2	3	4	5	6	7	8
LL	1	2	3	4	5	6	7	8

Region of interest

☐ Lower jaw ☐ Upper jaw ☐ Small Fov (Please detail the area of interest below.) Reason (e.g. Implant planning)

Justification

Software options for Cone Beam CT Scans

☐ CT Viewer ☐ DICOM ☐ Please contact me to discuss options

Delivery options

☐ CD (Patient) ☐ Online Data Transfer

Notes e.g. specific imaging parameters/protocols/concerns: .....

.....

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Sign off

☐ I would like this patient's radiographic examination to be reported upon by your consultant

☐ I will make my own reporting arrangements