DENTALSUITE
STANTONBURY

CBCT Referral Form

Please complete the form and post it to:
Dental Suite, Stantonbury, Milton Keynes
MK14 6BL, Tel. 01908-221800
or scan and email it to dental.suitemk@nhs.net

REFFERING PRACTIONERS DETAILS:
Name:
Practice:
Address:
Postcode:
phone:
Mobile:
E-mail:

PATIENT DETAILS:
Name:
D.O.B:
Address:
Postcode:
phone:
Mobile:
E-mail:

AREAS OF INTEREST FOR CBCT ONLY						Mandible:				Maxilla:			Both:			
UR8	UR7	UR6	UR5	UR4	UR3	UR2	UR1		UL1	UL1	UL3	UL4	UL5	UL6	UL7	UL8
LR8	LR7	LR6	LR5	LR4	LR3	LR2	LR1		LL1	LL2	LL3	LL4	LL5	LL6	LL7	LL8

Is The Patient Pregnant			
Yes		No	

2D IMAGINING	
Panoramic (OPG)	

Extras	
Radiology Report	

PAYMENT METHOD	
Dentist/Practice	
Patient	

Justification for X-RAYS	
Dental Implants	
Bone Graft	
Impacted Teeth	
Endodontics	
Sinus Exam	
TMJ	
Orthodontics	
Other	
If other please specify:	

CLINICAL INDICATION (Mandatory)

SIGNATURE:	
DATE:	