ENDO MISHRA

The root canal specialist

Referral for Cone Beam CT Scan

CT Scan Referral Form

Referring Practitioner

Name

GDC number

Address

Telephone Number

Email

Patients Details

Patient's name

Title

DOB ☐☐ ☐☐ ☐☐☐☐

Gender ☐ Male ☐ Female

Email

Landline

Address

Mobile

Region to Scan

Type of image require

- ☐ Digital Panoramic
- ☐ Cone Beam CT

Clinical Indication / Reason for Scan

CBCT

- ☐ 4x4cm
- ☐ 8x8cm
- ☐ L ☐ R ☐ TMJ or ☐ sinus - please specify region

Questions to be answered

Panoramic/ OPT

- ☐ OPT (Whole)
- ☐ L or ☐ R (Side)

Areas Of Interest

UR8	UR7	UR6	UR5	UR4	UR3	UR2	UR1	UL1	UL2	UL3	UL4	UL5	UL6	UL7	UL8
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
LR8	LR7	LR6	LR5	LR4	LR3	LR2	LR1	LL1	LL2	LL3	LL4	LL5	LL6	LL7	LL8
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

- ☐ Yes please provide a radiologist report on the patients's radiographic examination
- ☐ No I will make my own arrangements for reporting on the image/s

Payment to be be paid by the patient on the day of imaging.

Signed

Date ☐☐ ☐☐ ☐☐☐☐

Print Name

Practice

Please state preferred method of contact

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