



Imaging Referral Form

Please fill out this editable PDF and send to info@northlakelandimplant.co.uk

Referring Practice		Patient Name	
Practice Address		Patient Address	
Referring Dentist		Patient Date Of Birth	
Practice Tel No.		Patient Tel No.	
Practice Email		Patient Email	
Imaging Requirements		Clinical Indication For Examination	
	2D OPG	CT SCAN	
Maxilla			
Mandible			
Both arches			
Small area			
<p>I can confirm that I have examined this patient and that the images requested are clinically necessary.</p>			
Signature		Date	