#smilesbygurms

Imaging Referral Form

Referring Dentist Details

Name of Referring Dentist:
Practice Name:
Practice Address

Contact Telephone:
Email Address:
Date of Referral:

Patient Details:	
FULL NAME:	
DATE OF BIRTH:	
ADDRESS:	
EMAIL:	
CONTACT TELEPHONE:	
DATE SUBMITTED:	

Type of Radiograph requested:	
PANORAMIC	☐
CEPHALOMETRIC	☐
DENTAL CBCT	☐
CLINICAL CONTEXT FOR REQUESTING THE ABOVE:	

Present Dental Condition and Relevant Medical History:

Reason For Referral: What information do you want the radiographic examination to provide: Define the anatomical area that the radiograph should cover: