smileconcepts
specialist referral, implant & aesthetic centre

CBCT (3D scan)

OPG request form

CS8100 Scanner

Referring IRMER practitioner name:
Practice address:
Practice tel:
Email address:

Patient name:
Patient address:
Preferred tel:
Email address:
Date of birth:
I, the patient agree to be referred to Smile Concepts for digital imaging as requested by my dentist and I have had the reasons for my referral explained to me.
Please sign: _____ Date:

This section MUST be completed IN FULL by the referring dentist only

PLEASE TICK OPG ☐ **or** Sectional 3D scan ☐

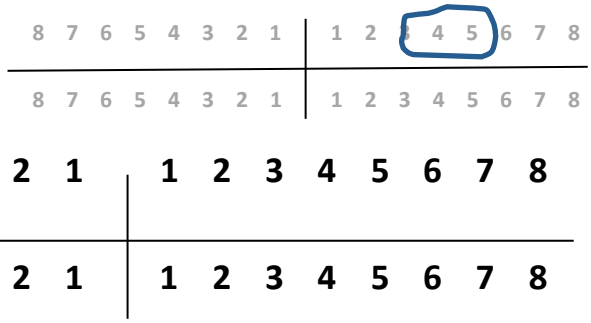
Justification for radiograph (this section must be completed)

_____

_____

Define the anatomical area that you would like the scan to cover, see example below. *

***i.e.**: UL4 pre-assessment for possible implant treatment.*



Please circle the area(s) to be scanned

Please tell us your preferences:

Please tick: Patient to pay at visit ☐ Invoice referring practice ☐

Please tick: Patient to take image away with them ☐ Send image to referring practice ☐

Signature of referring dentist Date:

The CBCT image will be reported on by the referring dentist.
Important information: it is essential that you complete all sections of this form in full.
All incomplete forms will be returned to the referring dental practice, which may result in a delay in your patients' treatment.
As per your service level agreement dental CBCT images will be reported on by the referring practice. The referring practice will be responsible for ensuring the clinical evaluation takes place and is properly recorded.