

# **Digital Radiography Referral**

Please tick as required;

- OPG
- Cone Beam CT Scan

Please complete justification for OPG/Scan

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Name of referrer; Dr \_\_\_\_\_ (Please Print)

Signature

Date

I confirm I will provide my own radiographic report unless I request otherwise below.

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## **PATIENT DETAILS**

Name

Address

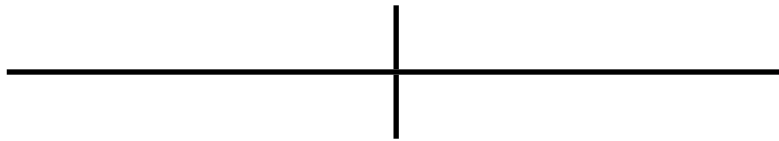
Post Code

Telephone Number

Date of Birth

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**REGION TO BE SCANNED** (Tooth notation) (5cm x 5cm field of view)



**Please indicate format required**

- Dicom
- Ez Viewer
- Simplant conversion (additional fee applies)

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## **FEES**

Please tick as required

- OPG - £25.00
- CT - £100 First & only scan
- CT - £150 2 scans or Full Arch (3 scans)
- CT - £200 Patient Maximum
- Simplant conversion - £50 per scan
- Report, Diagnosis & treatment planning - £200 (Report to be provided by referring dentist unless requested)

**We are pleased to accept payment by cash, cheque or most major credit cards.**

**Please indicate fee payer**

- Referring Dentist
- Patient

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For Office use only

Date Paid

Amount

Method