WESSINGTON DENTAL
LEADING THE WAY

Imaging Referral Form

Please complete details and circle/mark examination(s) and reporting required.

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			

I can confirm that I have examined this patient and that the images requested are clinically necessary.

Signature	**Date**