



# IMAGING REFERRAL FORM

**Referred By:**

Name ..... Email .....

Address ..... Tel.....

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**Patient Details:**

Title.....Forename ..... Surname .....

DOB...../...../..... Tel .....

Email .....

Possibility of pregnancy?  Yes  No

**Billing:**  Patient pays directly (I have advised patient of charge)  Invoice invoice practitioner

**Image Format:**  DICOM File  Multifile DICOM  Image with viewing software  Cloud storage (secure link emailed)

**Radiology:**  Please supply a radiologist report

## Examination Required

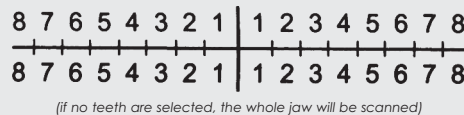
- Digital Panoramic**  **Digital Cephalometric:**  With tracing report  **Optical Scan:**  Model  Wax-up
- Cone Beam CT**  My patient will wear a stent

Purpose: (Mandatory) .....

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**Region of Interest:****Dental:**

- Lower Jaw
- Upper Jaw
- Small Volume: please us the tooth diagram

**Imaging Justification:**

- Implants  Sinus Exam
- Bone Graft  TMJ
- Impacted Teeth  Oral Pathology
- Endodontics  Ortho

**Notes:** e.g. specific imaging parameters / protocols / scanner preference / concern / medical history

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**IRMER 2000 Regulations:** Malmin Dental does not routinely report upon referred scans or radiographs.

To comply with the IRMER 2000 regulations all radiographs and scans are required to be reviewed and reported into the clinical notes by the referring practitioner. Malmin Dental strongly recommends that all CT and other radiographic examinations should be reported upon to rule out the possibility of coincidental pathology.

**Signed:****Date:**