

# Patient Radiograph Referral Form

## Sender Details & Delivery Address

(Please Use Capital Letters)

Tel : \_\_\_\_\_ Email : \_\_\_\_\_

## Booking Details

Patient Name : \_\_\_\_\_ Surname : \_\_\_\_\_

DOB : \_\_\_\_\_ Tel : \_\_\_\_\_

## Area of Interest

Mandible  Maxilla  Both Jaws

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Is the patient coming with a radiographic template? Yes  No

Is the patient possibly pregnant? Yes  No

## 3D CBCT Format

Implants  Impacted Teeth  Sinus   
Other \_\_\_\_\_

## 2D Radiography

Ortho  Impacted Teeth  Digital panoramic (OPG)   
Other \_\_\_\_\_

## Output

CT CBCT will be sent via CD-Rom format with a planner viewer and the digital OPG will be sent via email.

Is a radiology report required? Yes  No

## Special Instructions

\_\_\_\_\_  
\_\_\_\_\_

## Signed By

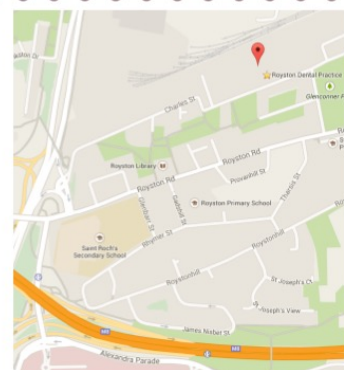
Practitioner Name : \_\_\_\_\_  
Signature : \_\_\_\_\_

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### Opening hours:

Mon 9-7  
Tue 9-7  
Wed 9-6  
Thu 9-6  
Fri 9-4  
Sat 9-1  
Sun closed



The radiographers at ImplantActive will take a scan with minimum dose, with best resolution according to area of interest and reason for the scan. The age, anatomy, physical size, and body mass of patient are all dependent factors.