MODWENA
ORTHODONTICS

Imaging Referral Form

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

REFERRING PRACTICE DETAILS			PATIENT DETAILS	
Practice			Full Name	
Address			Address	
Dentist			Date of Birth	
Tel No.			Tel No.	
Email			Email	

IMAGING REQUIREMENTS			CLINICAL INDICATION FOR EXAMINATION
True 2D OPG			
3D Cone Beam CT			
Small FOV	Medium FOV	Large FOV	
Maxilla	Mandible	Both jaws	
Single arch	Dual arch		

DELIVERY OF IMAGES	REPORTING ARRANGEMENTS*
CD	Written evaluation by referrer
3600 Connect / Kodak Freeview	Written evaluation by Radiologist

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

Signature	Date

*To comply with IRMER 2000 regulations there must be a written evaluation of all examinations. This should include any co-incidental anatomy/pathology visible on scans. It is the referrers responsibility to ensure an evaluation takes place.