oracle
DENTAL CLINICS

Dental Imaging Centre

Referral Form

PRACTITIONER DETAILS & DELIVERY ADDRESS

Name of Practitioner:

Practice name:

Address:

Telephone:

Email:

PATIENT DETAILS

Appointment Date: / /

Time:

Forname:

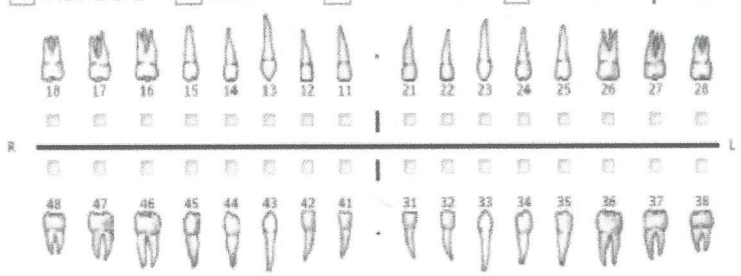
Surname:

Date of Birth: / / ☐ Male ☐ Female

Telephone:

AREA OF INTEREST CBCT ONLY

☐ Mandible ☐ Maxilla ☐ Both Jaws ☐ Sectional/quadrant



(If no teeth are selected the whole jaw will be scanned)

Is the patient coming with a radiographic template? ☐ Yes ☐ No

Is the patient possibly pregnant? ☐ Yes ☐ No

CBCT OUTPUT

☐ CD-ROM ☐ FTP & Email ☐ Photo paper

2D IMAGING

☐ Digital Panoramic (OPG)
☐ Digital Cephalometric
☐ Ceph Tracing Report

2D OUTPUT

☐ FTP & Email
☐ PACS Cloud Viewer
☐ Photo Paper

PAYMENT ☐ Doctor ☐ Patient

CBCT FORMAT

☐ I-CAT Vision
☐ PACS Cloud Viewer
☐ DICOM Files
☐ SimPlant Planner
☐ SimPlant OneShot
☐ SimPlant View

JUSTIFICATION FOR X-RAY EXTRAS

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

☐ Extra copy
☐ Pathology Report
☐ Radiology Report
☐ SimPlant Express

CLINICAL INDICATIONS: (mandatory)

Signature:

I confirm that I will write or obtain my own reports on this CT scan _____

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