

SCANNER REFERRAL FORM

REFERRING GDP:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Email Address: _____

PATIENT:

Name: _____ DOB _____

Address: _____

Telephone: _____ Fax: _____

REASON FOR REFERRAL:

CT SCAN OPTIONS: (Please circle)

OPG

CT SCAN

For CT Scan only: (Please circle)

MAXILLA

MANDIBLE

RELEVANT MEDICAL DETAILS:

Signature: _____

Print Name: _____

Date: _____

Please return to: Queensway Dental Practice, 170 Queensway, Billingham, Teesside.
TS23 2NT