

# THE SCANNING SUITE

## IMAGING REFERRAL FORM

**Referred By:**

Name ..... Email .....  
Address ..... Tel.....  
.....

**Patient Details:**

Title.....Forename ..... Surname .....  
DOB...../...../..... Tel ..... Address .....  
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

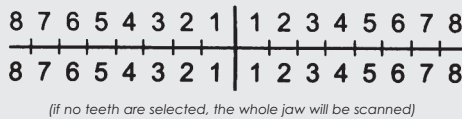
**Intra Oral Scanning - Trios 3 Colour**

- Digital Impression  Orthodontic Aligners
- Mandible  Maxilla  Both Jaws

Purpose: (Mandatory) .....  
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**Region of Interest:**

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



*(if no teeth are selected, the whole jaw will be scanned)*

**Imaging Justification:**

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

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

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**IRMER 2000 Regulations:** The Scanning Suite 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. The Scanning Suite strongly recommends that all CT and other radiographic examinations should be reported upon to rule out the possibility of coincidental pathology.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_