OXFORD PLACE DENTAL
DEDICATED TO IMPLANTS AND ORTHODONTICS

Cone Beam CT: Imaging Referral Form; please ensure a service agreement is in place between your practice and OXFORD PLACE DENTAL prior to sending this referral. We accept both hard and digital copies of all forms.

All dental CBCT images are to be reported by the referring practitioner.

Patient details

Name		Date of birth:	
Address			
Contact tel	H:	W:	M:

Referrer details

Name	
Signature	
Date of referral	

Justification

Clinical context for requesting a dental CBCT examination	
Details of scan (anatomical area) authorised	

Scan information (completed by OXFORD PLACE DENTAL)

Name of operator	Dr Amir Abedi
Signature	
Date of scan	
Exposure factors used	