



BOND DENTAL CLINIC

CBCT and OPG Referral Form

*Confidential and Protected
Document*

Referring Dentist Details

Referring Dentist Name: _____ Date of Referral: _____
Practice Name: _____ Telephone: _____
Practice Address: _____
Practice Email Address: _____

Patient Details

Title: _____ First Name: _____ Last Name: _____
Middle Name(s): _____ Date of Birth: _____
Address: _____ Postcode: _____
Email Address: _____ Home/Mobile Number: _____

Purpose of Referral:

(fees collected directly from the patient)

☐ OPG £85 ☐ CBCT without report £195 ☐ CBCT with report £295

Referral Requirements:

The referring dentist is responsible for supplying us sufficient information to justify an appropriate exposure. We request all parts of this form to be completed in advance to avoid any delay arranging the patients appointment.

Reason and Justification: _____

Relevant Medical history: _____

2D field of view required:

Full: ☐ Full OPG inc condyles ☐ Full OPG excluding condyles ☐ Condyles only ☐ Bitewings (if patient unable to tolerate I/O films)

Sectional: ☐ URQ ☐ ULQ ☐ Full Maxilla ☐ LRQ ☐ LLQ ☐ Full Mandible

Exposure: Patient ☐ Regular (high quality image) ☐ Quick (reduced exposure, good quality image)

Size: ☐ Size 1 (child) ☐ Size 2 (small adult) ☐ Size 3 (average adult) standard exposure ☐ Size 4 (large adult)