BELMORE

DENTAL STUDIO & IMPLANT CLINIC

CT Scan Patient Referral Form

Patient Details

Title _____

Patient Name _____

D.O.B _____

Patient Address _____

_____

_____

Postcode _____

Tel (Home) _____

Tel (Work) _____

Tel (Mobile) _____

Email _____

Referring Dental Practice

Dentist Name _____

Address _____

_____

_____

Email _____

Telephone _____

Fax _____

CT Scan Requirements

Radiographic Markers for Patient?

Yes ☐ No ☐

Maxilla ☐ Mandible ☐

Specific Tooth or area _____

All scans are parallel to Occlusal plane

unless otherwise stated below

Reason for Scan and Justifications

_____

_____

_____

Special Instructions

_____

_____

_____

_____

Signature

_____

GDC Reg. No _____

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