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ORANMORE
ENDODONTICS

Web: www.paulmccabe.ie

Email: reception@paulmccabe.ie

Referral Form for CBCT & OPG Scan

Scan required: CBCT ☐

OPG ☐

Date of Request:

Patient Details
Patient name:
Date of Birth:
Address:
Contact telephone:

Practitioner details
Referring Practitioner:
Practitioner email:
Telephone no:

Area(s) to be investigated: **(CBCT scan only)**

1) Tooth number: _____
2) Full arch upper: ☐
3) Full arch lower: ☐
4) Both Full upper and lower arches: ☐
5) Other: _____

Reasons for Scan: _____

Additional Comments: _____

_____

I understand that this scan will not be reported on and that this is the responsibility of the prescribing clinician:

Signed: _____

Prescribing Clinician