**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.**

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| Patient details |
| Name |  Date of birth: |
| Address |  |
| Contact tel | H: W: M: |
| Referrer details |
| Name |  |
| Signature |  |
| Date of referral |  |

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| 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 |  |
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