**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 |  |  |  |  | | --- | --- | | 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 |  | |  | | |