Kings Dental Clinic
A Lifetime of Brighter Smiles

Kings Dental Clinic
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OPG REFERRAL FORM

PATIENT'S DETAILS

Title: MR, MRS, MS, MISS, MASER

FIRST NAME: ______________________________

SURNAME: ______________________________

DATE OF BIRTH: ______________________________

TELE (HOME): ______________________________

TELE (MOBILE):______________________________

EMAIL: ______________________________

ADDRESS: ______________________________

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JUSTIFICATION FOR SCAN

- ☐ **IMPLANT TREATMENT PLANNING**
- ☐ **ORTHPDONTIC**
- ☐ **IMPACTED TEETH**
- ☐ **ENDODONTIC**
- ☐ **TMJ**
- ☐ **OTHER (PLEASE SPECIFY)**

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COST: £65

TO BE COMPLETED BY THE REFERRING PRACTITIONER

This will act as the practitioner's signature: I hereby authorise Kings Dental Clinic to carry out an OPG on my behalf.

The results of the scan will be returned via email. I am responsible for assessing the data and referring to the necessary specialties as clinically indicated.

Kings Dental Clinic will not be responsible for assessing the OPG for the suitability of treatment or for ultimately identifying and referring pathology; by referring the patient I am accepting this responsibility. The HPA CRCE010 guidelines suggest that attendance of Radiology Training Courses is deemed a regulatory requirement for all users of radiographs, including those who are simply referring patients for acquisition of an OPG. I accept that it is my responsibility to obtain the necessary qualification in order to refer and evaluate the data requested by me and provided by Aura Dental. Alternatively, I will arrange for a Consultant Radiologist to rule out coincidental pathology.

YOUR SIGNATURE:______________________________

REFERRING PRACTITIONER: ______________________________

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PRACTICE NAME: ______________________________

ADDRESS: ______________________________

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TELEPHONE: ______________________________

EMAIL: ______________________________

GDC: ______________________________

ADDITIONAL COMMENTS: ______________________________

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DATE: ______________________________

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