Widnes Dental Practice
59 Victoria Road
Widnes
WA8 7RP
0151 423 5623
widnesdentalsurgery@gmail.com

CT Scan Referral Form

REFERRED BY

Dentist: _____ GDC_____

Practice: _____ Address: _____

Telephone: _____ Post Code: _____

Signature: _____ **Date**: _____

PATIENT DETAILS

Title: _____ Forename: _____ Surname: _____

Date of Birth : _____ Mobile Number: _____

Address: _____ Post Code: _____

Possibility of pregnancy: _____

Is patient bringing stent? _____

CBCT/OPT REFERRALS

☐ Digital Panoramic

☐ CBCT

FOV

☐ 5x5 (sectional) ☐ 8x5 (single arch) ☐ 8x9 (both arches)

Region of interest and purpose/justification of

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

REASON FOR REFERRAL

Once completed, please bring this form along with you to your appointment.
Payment is due when services are rendered.

Widnes Dental Practice is not responsible for image interpretation, reading of findings. The diagnosis and treatment planning is the responsibility of the referring dentist.