Ferring Dental Practice

CEPH & OPG REFERRAL FORM

Referring Dentist Details		Scan request Details	Area – Sectional Quadrant
Name:		OPT/OPG	Mandible – Lower Jaw ☐
GDC No:		CEPH	Mandible – Upper Jaw ☐
Practice Name:			Both Jaws ☐
Postcode:			
Email: Telephone:			

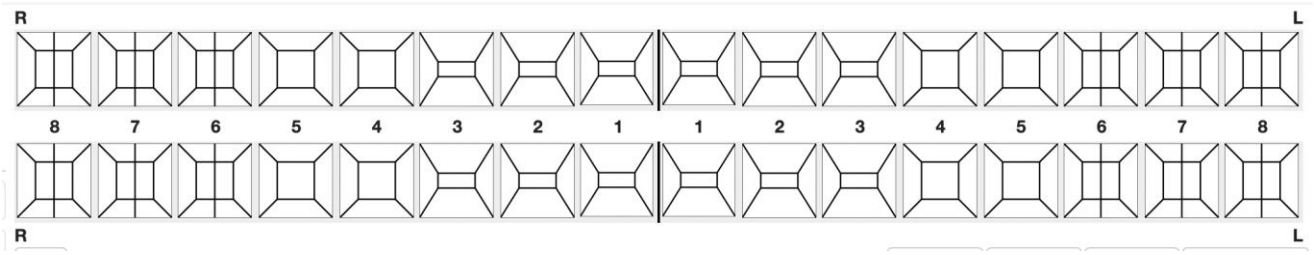
Patient Details			Comments/Notes
Patient Name			
Male / Female			
Pregnant			
DOB			
Address			
Post Code			
Contact No's.			
Patient Signature			
Date of referral			
Date of scan			
Scan sent Date			
Signature of performer			
GDC No.			

Ferring Dental Practice

Scan Details	CEPH ☐	OPT/OPG ☐
Type of scan		
Scan Template to be fitted	Yes ☐	No ☐
Justification for Scan		

Scan Size (please indicate area on Diagram)

Sectional
Quadrant
Mandible (Lower Jaw)
Mandible (Upper Jaw)
Both Jaws
(If no teeth specified, full jaw will be scanned



Referring Dentist Print Name	Signature:	Date:	Practice Acceptance Y/N