|  |  |
| --- | --- |
| **Dental Hospital – Radiology request form** | **Affix patient I.D. label or complete details:** |
| **Request for:** | Surname: | MRN: |
| Dental Imaging only |  | Forename: | NHS No: |
| Imaging and Report - see sections below \* |  | Address: | DOB |
| Report only |  |  |  |
| Mounting of radiographs |  |  |  |
| Postcode: | Gender: |
| **Patient category:** | **Requested dental images (use Palmer notation):** |
| Hospital |  |
| NHS Practice |  |
| Private |  |
| **Patient pathway** ***Please tick*** | **For CBCT please state: large/small volume. High res / standard / low dose and area of interest and tick the declaration below.**Referrals for Cone Beam CT imaging from external sites- it is assumed that referrers have undertaken Level 1 CBCT training, and that any clinician acting as IR(ME)R Operator /Reporter has undertaken Level 2 CBCT training. By referring for the above CBCT I confirm that I am in compliance with the above (please tick)  |
| Patient can leave after x-ray  |  |
| Patient to return to department |  |
|

|  |  |
| --- | --- |
| Urgent |  |
| Routine |  |
| Cancer waiting time |  |

**Consent for imaging has been taken \*** **Relevant clinical information and justification for imaging \* :** |
| **Medical History \* Pregnant : Yes / No / N/A** |
| **Relevant previous imaging (including dates) \* :** |
|
|
| **Images to be reported (including dates) \* :** |
| **Clinical question to be answered in report \* :** |
| **Requesting clinician name / grade:** | **Signature:** | **Date:** | **Consultant:** |
| **Referring department/ Practice address:** | **Department contact number:** |
| **FOR OFFICE USE ONLY** | **Date Received:** | **Appointment Requested:** |
| **Date:** |  |
| **Date Vetted:** |
| **Time:** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FOR RADIOGRAPHER USE:** | **Room:** | **Rad:** | **Int:** | **Ext:** | **Occ:** | **Slot No’s** |

**INCOMPLETE FORMS WILL BE RETURNED**