|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Dental Hospital – Radiology request form** | | | | | | | **Affix patient I.D. label or complete details:** | | | | | | |
| **Request for: pls tick** | | | | | | | 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 ( in house only) - 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( enables reporting Small Vols only)  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**