Acton Vale
DENTAL CENTRE

OPG REFERRAL FORM

Patient Details

Title: Mr | Mrs | Ms | Miss | Master | Dr | Prof.

First Name: _____

Surname: _____

Date of Birth: _____

Tel (Home): _____
Tel (Work): _____
Tel (Mobile): _____

Email: _____

Address: _____
_____
_____
_____

Justification for Scan

Implant Treatment Planning ☐

Orthodontic Assessment & Planning ☐

Impacted Teeth Assessment: ☐

Endodontic Assessment: ☐

TMJ: ☐

Other (Please specify): _____
_____
_____
_____
_____
_____

Cost: £80

TO BE COMPLETED BY THE REFERRING PRACTITIONER

This will act as the practitioner's signature: I hereby authorise Acton Vale Dental Practice 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.

Acton Vale Dental Practice and the Operator 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 CRCE-010 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: _____
_____

Practice Name: _____

Address: _____
_____
_____

Telephone: _____

Email: _____

GDC: _____

Additional Comments: _____
_____
_____

Date: _____