Dental Cone Beam
CT Imaging Referral Form

Premier Dental Clinic

To be completed by the referrer

PATIENT DETAILS

Name

Date of Birth
dd/mm/yyyy

Contact Telephone N°
daytime
mobile

Address

Email Address

IRMER REFERRER DETAILS

Name

Date of Referral
dd/mm/yyyy

Contact Telephone N°
daytime

Address

Email Address

The clinical context for requesting a dental CBCT examination

What information do you want the dental CBCT examination to provide?

Define the anatomical area that the scan should cover

ON COMPLETION: Please email this form to reception@premierdentalclinic.co.uk or post to Premier Dental Clinic, 77 Beckenham Lane, Shortlands, Bromley, Kent BR2 0DN. If you have any problems or questions filling out this form please call us on 0208 460 9150.