



## OPG IMAGING REQUEST FORM

### CLINICIAN DETAILS

Clinician name	<input type="text"/>
GDC number	<input type="text"/>
Practice name	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Contact Number(s)	<input type="text"/>
Email	<input type="text"/>

### PATIENT DETAILS

Title	<input type="text"/>
First name	<input type="text"/>
Surname	<input type="text"/>
Date of Birth	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Contact Number(s)	<input type="text"/>
Email	<input type="text"/>

### RELEVANT MEDICAL HISTORY (please specify medications and allergies)

### BRIEF PATIENT HISTORY

### JUSTIFICATION FOR OPG

### SERVICE REQUIRED

- Full panoramic
- Extra-oral bitewings
- Sectional (please detail: left, right or central)

### PAYMENT

- Patient at appointment (£50.00)
- Invoice referring practitioner

It is the responsibility of the referring clinician to report on all requested images.

Clinician signature \_\_\_\_\_

Date of referral \_\_\_\_\_

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