SHARROW VALE
DENTAL CARE

OPG IMAGING REQUEST FORM

CLINICIAN DETAILS

Clinician name	
GDC number	
Practice name	
Address	
Postcode	
Contact Number(s)	
Email	

PATIENT DETAILS

Title	
First name	
Surname	
Date of Birth	
Address	
Postcode	
Contact Number(s)	
Email	

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
- ◯ Invoice referring practitioner

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

I confirm that the above named patient has consented to onward referral for dental imaging and to being contacted by Sharrow Vale Dental Care.

Clinician signature _____

Date of referral _____

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