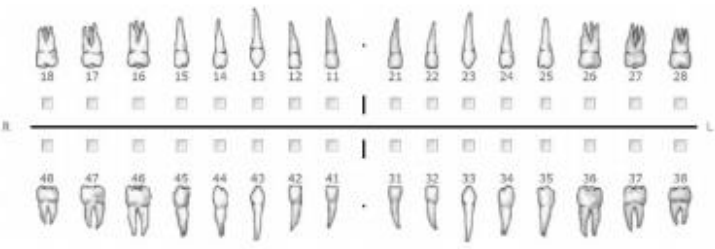


CBCT REFERRAL FORM Acteon X-Mind Trium

<p>Patient Details</p> <p>Title: Mr Mrs Ms Miss Master Dr Prof.</p> <p>First Name: _____</p> <p>Surname: _____</p> <p>Date of Birth: _____</p> <p>Tel (Home): _____</p> <p>Tel (Work): _____</p> <p>Tel (Mobile): _____</p> <p>Email: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Referring Practitioner: _____</p> <p>_____</p> <p>Practice Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>Telephone: _____</p> <p>Email: _____</p> <p>GDC: _____</p> <p>Additional Comments: _____</p> <p>_____</p> <p>_____</p> <p>Date: _____</p>
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TO BE COMPLETED BY THE REFERRING PRACTITIONER

<p> <input type="checkbox"/> Mandible <input type="checkbox"/> Maxilla <input type="checkbox"/> Both Jaws </p>  <p> Is the patient coming with a radiographic stent? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient possibly pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No </p> <p> CBCT Format: DICOM Email to: Patient <input type="checkbox"/> Referrer <input type="checkbox"/> </p> <p> CD containing images to be: Given to patient <input type="checkbox"/> Posted to Referrer <input type="checkbox"/> </p>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td><input type="checkbox"/></td><td>Implants</td></tr> <tr><td><input type="checkbox"/></td><td>Bone Graft</td></tr> <tr><td><input type="checkbox"/></td><td>Impacted Teeth</td></tr> <tr><td><input type="checkbox"/></td><td>Endodontics</td></tr> <tr><td><input type="checkbox"/></td><td>Sinus Exam</td></tr> <tr><td><input type="checkbox"/></td><td>TMJ</td></tr> <tr><td><input type="checkbox"/></td><td>Oral Pathology</td></tr> <tr><td><input type="checkbox"/></td><td>Ortho</td></tr> </table> <p> Payment: <input type="checkbox"/> Referrer <input type="checkbox"/> Patient </p>	<input type="checkbox"/>	Implants	<input type="checkbox"/>	Bone Graft	<input type="checkbox"/>	Impacted Teeth	<input type="checkbox"/>	Endodontics	<input type="checkbox"/>	Sinus Exam	<input type="checkbox"/>	TMJ	<input type="checkbox"/>	Oral Pathology	<input type="checkbox"/>	Ortho
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