## <u>Smileworks</u>

## CBCT / Radiography Referral Form

Practitioner Name	Patient Name
Practice Name & Address	Patient Contact Number
	Patient DOB
Practitice Contact Number	Male Female
Practitice Contact Email	Patient Contact Email
TYPE OF IMAGE	T AREAS OF INTEREST
	elected the whole jaw will be scanned
Ceph 18 17 16 15 14 1 CBCT	3 12 11 21 22 23 24 25 26 27 28
R	3 42 41 31 32 33 34 35 36 37 38
<b>CLINICAL INDICATIONS</b> (specify resolution - low dose for ortho, standard for implantology or high for single tooth / endo)	Is patient coming with a radiographic template? YES NO Is the patient possibly pregnant? YES NO
	Justification for exposure Implants I Implacted teeth 2D Output
	Implants     Impacted teeth     2D Output       Bone graft     Sinus exam     Email
	Ortho TMJ Dropbox
	Endo
	Ine Metquarter
	Liverpool ONE, 1a Kenyons Steps, Liverpool L1 3DF
SIGNATURE:	Located in: Liverpool ONE
E a Lord St	smileworksliverpool.co.uk
anes Street  ■ Oueensway Tunnel Lord St. Derby Square Liver	0151 236 5166
rpool Waterfront	The Bluecoat C The area of the
Noc	lafone 😁 Jungle Rumble
20 Museum of Livernool	vorks Liverpool
Museum of Liverpool	oukest a
	e to Duke St Alma de Cuba

Please complete and send as a jpeg or PDF to concierge@sexydentistry.com

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