first contact health

SCANNING + DIAGNOSIS + TREATMENT

CT Dental Scanning Referral Form

Patient details:

Title:		*Circle one* **Insurance/Self-Funding**
First Name:		
Surname:		
DOB:		Insurer:
Telephone:		
Address:		Policy #:
		Office use only – Auth code:
Postcode:		

Clinical history and presentation:

Clinical question to be answered:

Region/s to be scanned:	Specific Area/s of interest:

Safety check	
Check if the patient is pregnant before referring. If "yes", please phone to discuss. It is the expectation that the scanning will be unable to proceed.	**ARE THESE IMAGES TO BE REPORTED? Yes/No** **ARTHROGRAM? Yes/No**

Referrer details:

Title:		Signature:
Name:		
Practice / Site:		
Speciality:		Date:
Address:		
		If reported, how would you like the report sent to you? Email
Telephone:		

Ladies Only

LMP Date:	Overrule: Y/N	I confirm I wish to undergo an XR examination despite being over 28 days since the end of my last menstrual period:
Reason:		Name: ____________________ Date: ________
Signature:		Signature: ____________________________

Please email completed forms to imaging.guernsey@firstcontacthealth.com