OPG REFERRAL FORM

Broom Road Dental Care
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S60 2SW

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www.josephfamilydental.co.uk
Please email completed form to broom@josephfamilydental.co.uk

REFERRER DETAILS

Name: GDC Number:	Practice address:
Email address:	Contact telephone:

PATIENT DETAILS

Name:	☐ Mobile tel:
DOB:	☐ Home tel:
Address:	☐ Email: PLEASE TICK PATIENTS PREFERRED METHOD OF CONTACT

Justification for scan

☐ Implant treatment planning
☐ Impacted Teeth Assessment
☐ TMJ
☐ Orthodontic Assessment & Planning
☐ Endodontic Assessment

Other (please specify)

To be completed by the referring practitioner

This will act as the practitioner's signature: I hereby authorise Joseph Family Dental Care to carry out an OPG on my behalf. The results of the scan will be returned via email. I am responsible for assessing the data and referring to the necessary specialties as clinically indicated. Joseph Family Dental Care and the Operator will not be responsible for assessing the OPG for the suitability of treatment or for ultimately identifying and referring pathology; by referring the patient I am accepting this responsibility. The HPA CRCE- 010 guidelines suggest that attendance of Radiology Training Courses is deemed a regulatory requirement for all users of radiographs, including those who are simply referring patients for acquisition of an OPG. I accept that it is my responsibility to obtain the necessary qualification in order to refer and evaluate the data requested by me and provided by Joseph Family Dental Care. Alternatively, I will arrange for a Consultant Radiologist to rule out coincidental pathology.

Signed (your signature): ……