



Please email form to:reception@30beaumontstreet.co.uk

OPG REFERRAL FORM

<p>PATIENT DETAILS</p> <p>Title: Mr Mrs Ms Miss Master Other:</p> <p>First Name:</p> <p>Surname:</p> <p>DOB:</p> <p>Tel (Home):</p> <p>Tel (Mobile):</p> <p>Email:</p> <p>Address:</p>	<p>JUSTIFICATION FOR RADIOGRAPH</p> <p>Implant Treatment Planning Orthodontic <input type="checkbox"/></p> <p>Assessment Impacted Teeth <input type="checkbox"/></p> <p>Assessment Endodontic Assessment <input type="checkbox"/></p> <p>TMJ <input type="checkbox"/></p> <p>OTHER (Please Specify): <input type="checkbox"/></p> <p>Cost £86</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p>PAYMENT:</p> <p><input type="checkbox"/> Referrer <input type="checkbox"/> Patient</p> </div>
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TO BE COMPLETED BY REFERRING PRACTITIONER

<p>I hereby authorise 30 Beaumont Street Dental to carry out an OPG on my behalf.</p> <p>The results of the radiograph will be returned via email. I am responsible for assessing the data and referring to the necessary specialties as clinically indicated.</p> <p>30 Beaumont Street Dental and the operator will not be re-sponsible for assessing the OPG for the suitability of treatment, for immediately identifying and referring pathology; by referring this patient I am accepting this responsibility.</p> <p>I certify that I have obtained the necessary qualifications in order to refer and evaluate the data requested by me and provided by 30 Beaumont Street Dental.</p> <p>I have obtained consent from the patient to share their personal data via non-encrypted email, in line with GDPR data security.</p> <p>Signature: _____ Date: _____</p>	<p>Referring Practitioner:</p> <p>GDC:</p> <p>Practice Name:</p> <p>Address:</p> <p>Telephone:</p> <p>Email:</p> <p>Additional Comments:</p>
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