

The Courtyard Clinic

Radiograph Referral Form

Panoramic/OPG Cephalometric CBT view

Patient details:

Name :

DOB:

Address :

Tel :

Mob :

Referring practitioner details :

Name :

Practice :

Address :

Tel:

Reason for referral :

Relevant medical history :

Referring practitioner's signature

Radiographic image to be

Emailed Copied to a CD Both