Request for Dental Radiological Examinations from Dental Practitioners

Please ensure ALL boxes are completed or the referral may be declined.
Completed forms must be signed by the referring dentist, scanned and emailed to:
DentalXrayReferrals@nnuh.nhs.uk

Date of request			
NHS number			
Surname			
Forename			
Date of birth (DD/MM/YYYY)			
Address (Including postcode)			
Contact number			
Examination requested			
Clinical history			
Specific question to be answered from imaging			
Patient mobility / health constraints			
Pregnancy status	Pregnant	Not Pregnant	N/A
Category of patient (please circle)	NHS	Private	
Urgency of examination (please circle)	Routine	Urgent	
Referrer's name			
Dental Practice Address			
Referrers signature & GDC Number			