

## CT & OPT Referral Form

### Patient Details

First Name ..... Date of Birth .....

Surname .....

Address .....

Postcode .....

Telephone Number ..... Mobile .....

### Area to be Scanned

Maxilla

OPT

Mandible

TMJ  (Open, Closed or Both)

### Clinical Information

Reason for Scan .....

### Type of Scan Required

**4cm x 4cm scan area £95**

Covers smaller areas e.g. wisdom teeth, TMJ's, unerupted canines and cysts.

**8cm x 8cm scan area £235**

Covers whole mandible and maxilla. Suitable for assessment of bone levels and nerve position prior to implant surgery

**OPT £48**

**Signature of Referring Dentist** ..... **Date** .....

**Address of Referring Dentist/Surgery** .....

**Please send all referrals to:-**

**Lucy Denton**  
**Specialist Radiographer**  
**Latchford & Latchford**  
**49 Castle Road**  
**Bedford**  
**MK40 3PL**

**Tel:- 01234 348899 Fax:- 01234 218080**