Radiograph Request Form (DPT)

Patient Details

Name	
Date of Birth	
Address	
Contact Details	Tel: E-mail:

Request and Justification

Clinical justification		
Information required and Anatomical area(s) the scan should cover		
Radiographs Required	[ ] Full Mouth DPT [ ] Sectional DPT *Specify area:*	*For CBCT images please use the CBCT request form*

Prescribing Dentist Details

Name	
Date of Referral	
Practice	
Address	
Contact Details	Tel: E-mail:
Image Format	[ ] JPG image [ ] DICOM file [ ] Printed Image [ ] Cloud storage (secure link emailed) [ ] CD posted to practice
Billing	[ ] Bill patient directly (Please advise of patient £50 charge) [ ] Invoice to practice
Signature	**The scan will not be reported on and this is the responsibility of prescribing dentist.**

For more information, visit KPTeeth.co.uk/imaging

Email to: Info@KPteeth.co.uk **Post to**: 1 Stuart Court, Kingston Park, NE3 2QF