GENERAL DENTAL PRACTITIONERS DENTAL X-RAY REQUEST FORM

General Dental Practitioner Details

Name:

Practice Address:

Practice Telephone Number:

Practice E-mail Address:

Patient Details

Name:

Address:

Daytime Contact Telephone Number:

Date of Birth:

Name of GP:

Examination Required	**Date**		
Reason for Examination			
Dental Diagnosis			
Suspected Pathology			
Treatment Progress			
Other:			
Exposure Factor	**KV**	**mA**	**Secs**
Radiograph			
Operator Comments			

Requesting Practitioner	Signature	
	Name	
This examination has been justified & authorised by:	Signature	
	Name	
Operator	Signature	
	Name	
Comments		

Note: As a Referrer under the Ionising Radiation Medical Exposure Regulations 2000 (IRMER) you are responsible for providing sufficient information to allow for identification of the patient and justification of the examination. This form must contain patient name, date of birth, examination requested, clinical details supporting examination requested, surgery contact details, referrers name and signature of referrer.