# DENTAL IMAGING REFERRAL FORM

## Patient Details

Name ..... D.O.B ... / ... / ...

Address ..... Suburb .....

## Examination Requested

**Dental X-Ray** ❑ OPG ❑ Lat Ceph ❑ PA Ceph ❑ TMJ 2D
❑ Bone Age ❑ Intra Oral

**CBCT** ❑ Endo Study ❑ Unerupted Teeth ❑ Implant Survey
❑ I.A.C Survey ❑ TMJ Survey ❑ Other .....

## Clinical Notes

Please note area of interest

Right 18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28 Left
48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38

## Comments

.....

## Referrer Details

Name ..... Clinic .....

Address ..... Provider No .....

Phone ..... Fax .....

Signature Copies To .....

.....

YARRA Radiology

**Locally owned and proud to support your community**

Pref Name ..... Pronoun .....
Sex at Birth ❑ M ❑ F
Medicare No. .....

**Billing**
❑ Private
❑ Pens/Conc
❑ Workcare
❑ TAC
❑ VET

**Gender Identity** (Opt)
❑ M ❑ F
❑ Not Listed .....
Transgender
❑ Y ❑ N
❑ Prefer not to say

**Clinical Alerts**
Is the patient pregnant? ❑ Y ❑ N

**Results**
❑ URGENT ❑ Download ❑ Fax
❑ Phone Ph .....

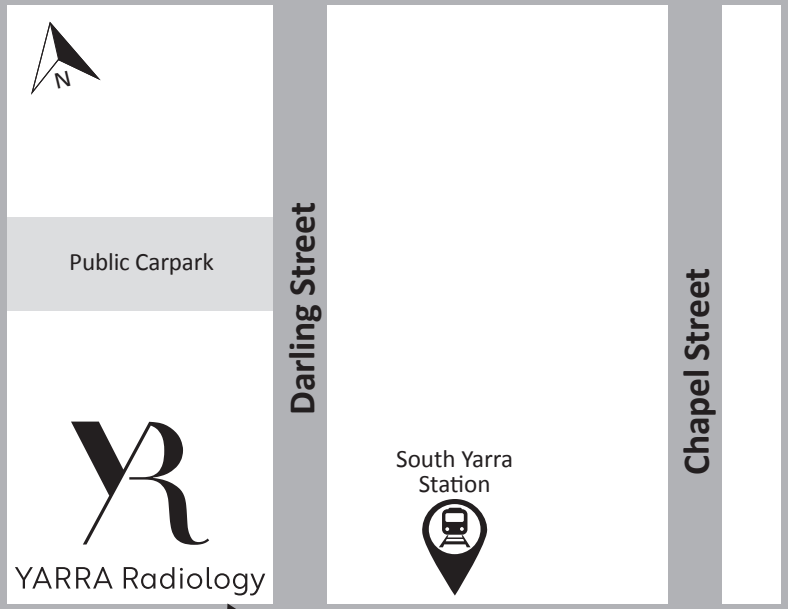
**Images**
❑ Films ❑ Online Images
❑ Email Email Add .....

## Appointments

**Phone: 1300 177 199**
**Online: yarraradiology.com.au**

MRI ▪ Low Dose CT ▪ Ultrasound ▪ X-Ray ▪ DEXA ▪ Mammography ▪ OPG ▪ CBCT ▪ Cardiac CTCA ▪ Women's Imaging ▪ Sports Imaging

# Locate Us




**Yarra Radiology South Yarra**

145 Toorak Rd, South Yarra, VIC

# Patient Information

Please bring any previous dental X-rays with you to your appointment.

You may eat and drink normally prior to your dental imaging procedure.

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