GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

University Dental Hospital
Ysbyty Deintyddol Athrofaol
Heath Park Parc Y Mynydd Bychan
Cardiff Caerdydd
CF14 4XY CF14 4XY
Phone / Ffôn 029 2074 7747

DENTAL RADIOLOGY REFERRAL FORM

Please ensure that all areas marked with an asterisk are completed, failure to do so will result in this referral being rejected.

Details of Patient

*****Surname: …… *First Name: ……

*Address: ……..

……..... *Post Code: ……

e-mail address…… * DOB: ..…../……./…….. Male/Female:

*Daytime telephone number: …….. NHS Number: …….....

Has the patient previously attended the dental hospital? YES/NO
Is this the first referral for the matter? YES/NO
Date of referral …….....

In order to ensure that patients needs are safely met and to comply with the Disability Discrimination Act, please complete the following:

*Mobility Assistance	None required		Wheelchair User		Other assistance (please state)	
*Sensory Loss	None		Sight		Hearing	
* Weight	Over 21st/133kg					

REFERRING PRACTITIONER – *Telephone Number……..

*GDP STAMP/DETAILS	GMP STAMP/DETAILS
***Dentist Name:**_____ ***GDC Number/FPC Number:**_____	***Doctors Name:**_____ ***GMC Number/FPC Number:**_____

***Signature of referring Practitioner.....**

***Reason for Referral**

Radiographic Opinion ☐ **Go to section 1** **Request for radiographs** ☐ **Go to section 2**

Section 1 - Radiographic opinion

Please supply clinical information and reason for radiographic opinion request.

Have you enclosed radiographs? Yes / No Original Film / Electronic Version

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Section 2 - Request for radiographs

***Please supply sufficient clinical information (including relevant medical history) to justify radiographic exposure.**

*Radiographic view requested

*Please confirm risks and benefits of the examination have been discussed with the patient ☐

For hospital use only

<table>
<tr><td colspan="4">Authorising staff signature</td></tr>
<tr><td colspan="4">If examination has changed risks and benefits of the examination have been discussed with the patient: ☐ Signature</td></tr>
<tr><td colspan="2" rowspan="3">Patient ID confirmed by
Self ☐
Parent ☐
Other ☐
Comments</td><td colspan="2">No. of images taken (including repeats)</td></tr>
<tr><td>IO</td><td>EO</td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">Exposure Factors</td><td colspan="2" rowspan="2">Equipment Used</td></tr>
<tr><td>kV</td><td>mA/mAs</td><td>Time</td></tr>
<tr><td colspan="2">Student
Signature</td><td colspan="2">Radiographer/demonstrator
Signature</td></tr>
<tr><td colspan="4">Date of examination :</td></tr>
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