smile club


Smile Club
1 Albert Road
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Stockport
SK8 5DB
**Please email form to**: info@mysmileclub.co.uk


# CBCT REFERRAL FORM

| **PATIENT DETAILS** | Referring practitioner: |
|---|---|
| Title: Mr \| Mrs \| Ms \| Miss \| Master \| Other: | GDC: |
| First Name: | Practice name: |
| Surname: | Address: |
| DOB: | |
| Tel (Home): | |
| Tel (Mobile): | Telephone: |
| Email: | Email: |
| Address: | |

I hereby authorise Smile Club to carry out an OPG on my behalf. The CBCT will be returned via email. I am responsible for assessing the data and referring to the necessary specialties as clinically indicated. Smile Club and the operator will not be responsible for assessing the CBCT for the suitability of treatment or for immediately identifying and referring pathology; by referring this patient I am accepting this responsibility. I certify that I have obtained the necessary qualifications in order to refer and evaluate the data requested by me and provided by Smile Club. I have obtained consent from the patient to share their personal data via non-encrypted email, in line with GDPR data security.

Signature: Date:

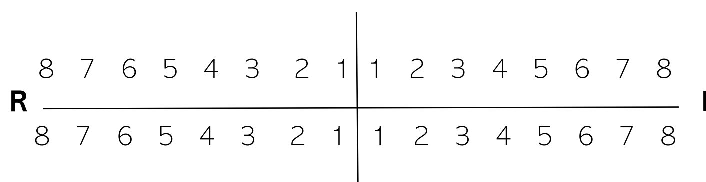
# TO BE COMPLETED BY REFERRING PRACTITIONER

Implant treatment planning ☐ Maxilla ☐ Mandible ☐ Both Jaws ☐

Bone Graft ☐

Impacted Teeth Assessment ☐

Endodontics Assessment ☐




TMJ ☐

Oral Pathology ☐ Is the patient coming with a radiographic stent? Y/N

Orthodontics ☐ Is the patient possibly pregnant? Y/N

**Payment**: **Referrer** ☐ **Patient** ☐