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

OPG REFERRAL FORM

PATIENT DETAILS

Title: Mr | Mrs | Ms | Miss | Master | Other:

First Name:

Surname:

DOB:

Tel (Home):

Tel (Mobile):

Email:

Address:

JUSTIFICATION:

Implant treatment planning ☐

Orthodontic Assessment ☐

Impacted Teeth Assessment ☐

Endodontic Assessment ☐

TMJ ☐

Other (Please specify):

Payment:

Referrer ☐ **Patient** ☐

I hereby authorise Smile Club to carry out an OPG on my behalf.
The radiograph 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 OPG 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:

Referring practitioner:

GDC:

Practice name:

Address:

Telephone:

Email:

Additional comments: