CLOUD RADIOLOGY

DENTAL IMAGING REQUEST FORM

Dr. Michael Crouch

ph 07 2112 2000
fax 07 2112 2001

Patient Name:.....

Patient Address:.....

..... D.O.B. .....

Your next appointment is on:..... at .....am. / pm.

EXAMINATION REQUIRED

- ☐ OPG (normal position)
- ☐ MOUTH OPEN
- ☐ MANDIBLE
- ☐ LATERAL CEPHALOGRAM
- ☐ FRONTAL CEPHALOGRAM
- ☐ TM JOINTS (open and closed)
- ☐ Transcranials
- ☐ Waters View
- ☐ MAXILLARY SINUSES
- ☐ CT DENTAL

CLINICAL DETAILS

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.....

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URGENT REPORT ☐ Phone / Fax No .....

☐ Email.....

FILMS Copy to .....

Time Required:.....am. / pm.

Account to: ☐ Medico-legal ☐ Workers Comp ☐ Patient

PRE-EXAMINATION CHECK

I confirm that prior to this examination the following processes were completed:

☐ Patient ID & Procedure Matching Process

☐ Informed Consent Obtained

MRP / Sono Signature.....

Date.....

FOR ALL EXAMINATIONS USING RADIATION

PREGNANT? ☐ YES ☐ NO

PT TO SIGN:.....

I confirm that prior to this examination the following processes were completed:

☐ A Justrification and Approval process

MRP Signature.....

REFERRER DETAILS: *These sections MUST be completed Provider Number*.....

Referrer Name*..... Specialty .....

Address*.....

..... Postcode ..... Telephone (B) .....

SIGNATURE* ..... Date*..... Facsimile (B).....

Your Doctor recommended you use Cloud Radiology. You may use anothr provider but please discuss with your doctor first

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X-Ray • Ultra Low Dose CT • Ultrasound • Mammography
Interventional Procedures • Echocardiography
BMD • Dental • Body Composition

STRATHPINE SPECIALIST CENTRE Suite 11/32 Dixon St, Strathpine QLD 4500