Lateral Cephalogram (Lat Ceph Radiograph)

Referring Dentist

Dentist Name:

Date Sent:

Practice name:

Practice address:

Postcode:

Practice Telephone:

Practice Email:

Patient Details

Title/Name:

Date of Birth:

Address:

Postcode:

Telephone/Mobile Number:

Email:

Preferred Contact Method:

Medical History:

FINEDON DENTAL PRACTICE

Lat Ceph Justification

Implant treatment planning ☐ TMJ ☐

Orthodontic Assessment & Planning ☐ Other (please specify) ☐

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<u>Lat Ceph Charges</u>

Lat Ceph	£60.00

YOUR PATIENT WILL BE ASKED TO PAY FOR THEIR SCAN AT THE APPOINTMENT UNLESS YOU INSTRUCT US OTHERWISE.

Patient informed of approximate cost ☐

I hereby authorise Finedon Dental Practice to carry out a Lat Ceph on my behalf. The results of the radiograph will be returned via email. I am responsible for assessing the data and referring to the necessary specialties as clinically indicated. Finedon Dental Practice and the operator will not be responsible for assessing the Lat Ceph for the suitability of treatment of 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 Finedon Dental Practice. I have obtained consent from the patient to share their personal data via non-encrypted email, in line with GDPR data security.

Referring Dentist Name ………………………………………………………………………….

Dentist signature ……………………………………………. GDC Number ……………………….

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