Victorian Dental Imaging Group

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DENTAL X-RAY REQUEST

Patient Details

Name____ DOB ___________________________

Address____ Contact Phone___________________

Examination Requested

Standard X-rays [ ] OPG [ ] Lat Ceph [ ] PA Ceph [ ] TMJs [ ] Bone Age [ ] Intra-Oral/s

Cephalometric Analysis [ ] Ricketts [ ] Steiner [ ] McNamara [ ] Downs [ ] Other____________________

Cone-Beam CT Scan [ ] Maxillary [ ] Mandibular [ ] Both Arches [ ] TMJ Study [ ] ENT [ ] Other

* Please include clinical notes below- assists us with adequate scan parameter selection and patient dose optimisation

Clinical Information

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Please select Area of Interest

Standard X-rays [ ] Examine Dentition [ ] 3rd Molars [ ] Caries Status [ ] Perio Status

Cone Beam CT [ ] Implant Study [ ] Impaction / Localisation [ ] IDC localisation [ ] Airway

Additional Clinical Notes & Special Instructions

Image Presentation

[ ] Email [ ] CD [ ] Paper Printout [ ] X-ray Film [ ] DICOM Data Only [ ] Include CBCT Viewer

Referring Provider Details

* Name____ * Provider No __________________________

* Signature on Printout _____________________________ * Date ______________________________

** Required by Health Insurance Act Legislation*