Parkway Clinic
Lamberts Road
SA1 Waterfront
Swansea
SA1 8EL
Tel:01792 455780
Email:enquiries@parkwayclinic.co.uk
Web:www.parkwayclinic.co.uk

PRIVATE SPECIALIST REFERRAL FORM

Please PRINT in BLOCK capitals

PATIENT DETAILS:

Name: ……………………………………………………………………………………

Date of Birth: ……………………………………………… Male / Female

Address:……………………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

Post Code:……………………………………………………………………………
Home Telephone No: ……………………………………………………………
Mobile Telephone No: ……………………………………………………………
Email address: ……………………………………………………………………

REFERRER DETAILS:

Referring Practitioner: ………………………………………………………

Practice Address: ………………………………………………………………

……………………………………………………………………………………

……………………………………………………………………………………

Practice Telephone No.: ……………………………………………………
Practice email address: ……………………………………………………
Date of Referral: ………………………………………

Patient's Name:	Date:
Patient Reference Number:	
DOB:	
Referring Clinician :	
Signature of Clinician	
Pregnancy: Yes/Possibly ☐ No ☐ Not relevant ☐	
Any relevant medical conditions:	

Examination Required (Please tick)
☐ CT MAXILLA ☐ CT MANDIBLE ☐ BOTH
All images will be taken parallel to the occlusal plane unless you specify a different orientation here:

Clinical Indication (Please specify)

It is an IRMER requirement that all the CT scans must be justified. Please give full clinical details of the site & anatomical features to be imaged.

Program Required Comments: (e.g. area to be scanned, Radiographic Guide etc)

☐ Vol 1 = 8 x8

☐ Vol 2 = 5 x 5

☐ Upper jaw

☐ Lower Jaw

☐ S1 = Sinus

☐ Other ……………………………………………………………………………………………………

Patients consent: ______________________ Date:

Referrer Signature: ______________________ Date:

Operator signature: ______________________ Date: