The Parkway
Private Clinic

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:

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