



The Parkway
Private Clinic

Parkway Clinic
Lamberts Road
SA1 Waterfront
Swansea
SA1 8EL

Tel: 01792 455780

Email: webmail@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:

X-Ray Prescription Form

Date:

Patient Name:

Number: Date of Birth:

Patient's GDP:

Dentist X-Ray Prescriber Signature:

X-Ray type:

Programme:

- | | | |
|--------------------------|----------------------------|----------------------------|
| 1) P1 Regular OPT | 2) P2 OPT without Condyles | 3) P10 Child setting |
| 4) P12 OPT anterior only | 5) BW1 Bitewings | 6) BW2 Anterior Periapical |
| 7) TM1.1 TMJ | 8) TM3 TMJ | |

Indication for X-Ray

- | | | |
|--|---|--|
| ☐ Caries | ☐ Unerupted teeth | ☐ Too carious for restoration |
| ☐ Retained root | ☐ Apical pathology | ☐ Wisdom teeth |
| ☐ Bone level | ☐ Pathology | ☐ Root morphology |
| ☐ Implants | ☐ Other | |

X-Ray examined by Date:

X-Ray taken by Date:

Patient/Guardian Consent Date: