Xray Referral form
to be completed by the referring practice

Section 1 - Patient details

Full Name	
Address	
Date of Birth	
Home Telephone	
Mobile telephone	
Email	

Referrer Details

Referrer Name	
Practice Name and Address	
Referrer Signature	
Referral Date	
Referrer Telephone	

Type of radiograph examination request:

Example CBCT:

The clinical context for requesting the above examination:

Relevant results of history, clinical examination and other imaging:

What information do you want the radiograph examination(s) to provide?

Define the anatomical area the radiograph(s) should cover:

Section 2 – To be completed by the receiving practice

Justification	
IRMER Practice name	
IRMER Practitioner signature	
Date	
Details of radiograph image (s)and/or scan authorised	

Radiograph Information

Operator name	
Operator signature	
Date of radiographic exposure(s)	
Exposure factors used	

Section 3: To be completed by reporting operator - Clinical evaluation

Reporting operator name	
Reporting operator signature	
Reporting operator signed date	
Outcome	