HOLLAND PARK
DENTAL CENTRE

Holland Park Dental Centre,
170 Holland Park Avenue, London, W11 4UH

Please email form to: reception@hollandparkdental.co.uk

OPG REFERRAL FORM

PATIENT DETAILS

Title: Mr | Mrs | Ms | Miss | Master | Other:

First Name:

Surname:

DOB:

Tel (Home):

Tel (Mobile):

Email:

Address:

JUSTIFICATION FOR RADIOGRAPH

Implant Treatment Planning ☐

Orthodontic Assessment ☐

Impacted Teeth Assessment ☐

Endodontic Assessment ☐

TMJ ☐

OTHER (Please Specify):

Cost £85

PAYMENT:

☐ Referrer ☐ Patient

TO BE COMPLETED BY REFERRING PRACTITIONER

I hereby authorise Holland Park Dental to carry out an OPG on my behalf.

The results of the radiograph will be returned via email. I am responsible for assessing the data and referring to the necessary specialties as clinically indicated.

Holland Park Dental and the operator will not be responsible for assessing the OPG for the suitabiltiy of treatment of for immediately identifying and referring pathology; by referring this patient I am accepting this responsibilty.

I certify that I have obtained the necessary qualifications in order to refer and evaluate the data requested by me and provided by Holland Park Dental.

I have obtained consent from the patient to share their personal data via non-encrypted email, in line with GDPR data security.

Signature: Date:

Referring Practioner:

GDC:

Practice Name:

Address:

Telephone:

Email:

Additional Comments: