Radiographic Assessment

Form 9

For office use

D D M M Y Y

CHI Number | | | | | | | | | | |

Surname _____

Forename _____

Age | | Sex | |

Examination Date

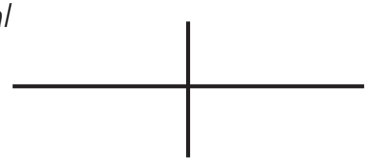
Day | | Month | | Year | | | |

Type of film(s)

Bitewings Horizontal R L *Periapical*
Vertical R L

Occlusal Upper Lower

Extra-oral OPG Lateral Ceph *Other*



Quality of films taken

Radiation Dose / Setting

Clinical indication for taking film(s), and suspected diagnosis

Radiographic Report

Clinical examination undertaken by:

Date

Films authorised by:

Date

Films taken by:

Date

Signature of Practitioner _____ **Date** _____