

# Radiographic Assessment

Form 9

Surname \_\_\_\_\_

Forename \_\_\_\_\_

Age

Sex

For office use

D D M M Y Y

CHI Number

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

Examination Date

Day

Month

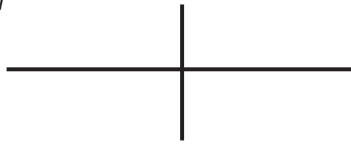
Year

## 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 \_\_\_\_\_