

## Service level agreement:

For the referral of patients for *specify type* examinations

Referring practice		Receiving practice	
Address		Address	
Tel		Tel	
Email		Email	
Name of employer*		Name of employer*	

Referral criteria
The document(s) specified here will be used by both parties as the basis for the referral of patients and the justification/authorisation of dental radiographic examinations:

Entitlement of people					
Enter below the details of all people at the referring practice who will refer patients for radiographic examinations and/or report on dental images. Evidence of suitable training must be provided.					
For completion by referring practice				For completion by receiving practice	
Names	GDC/GMC Registration number	IRMER17 roles (tick)		Training OK?	Registration OK?
		Referrer	Operator (reporting)		

Signatures of agreement			
We the undersigned agree: (1) to use the referral criteria above; (2) that evidence of adequate training has been provided for each of the people named above appropriate to their IRMER17 roles; (3) that adequate information will accompany each referred patient to allow the justification process to proceed, as set out in the standard imaging referral form attached.			
For the referring practice		For completion by receiving practice	
Name*		Name*	
Signature		Signature	
Date		Date	

\* The person who signs here should be the employer or, in the case of a body corporate or other situation where the "employer" may not be available, a suitable representative (eg, a dentist at the practice who is involved with the referrals) who is able to sign on the employer's behalf.