CBCT Referral form

Patient Details:

Title: First Name: Last Name:

Date of Birth:

Address:

Post Code:

Home Tel: Mobile Tel:

Email:

Referring Dentist Details:

Dentist Name: Practice Name :

Practice Address:

Post Code:

Practice Telephone: Practice Email:

Justification For CBCT (required under IR(ME)R 2017 (must be completed)

CBCT Scan Requirements:

All Scans will be parallel to the occlusal plane unless otherwise specified. Standard image resolution will be supplied unless you specifically request high resolution or Endo (50x50mm FOV only)

Stent to be worn Ò Yes Ò No

Field of View:

Ò Full Upper Ò Full Lower Ò Full upper and Lower

Ò Sectional (50x50mm) Please mark area below

R 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8 **L**

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

Please inform patient of the price. CBCT £200

To view are scan you will require the Romexis software viewer.

We do not report on scans, if you do require a report you can contact JM Radiology

Dentist Signature: GDC Number

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