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**For scanning centre use only:**

<b>Justification</b>	
Name of IRMER17 practitioner	
Signature	
Date	
Details of scan authorised	
<b>Scan information</b>	
Name of operator	
Signature	
Date of scan	
Exposure factors used	
Clinical evaluation (reporting)*	
Name of operator (reporting)	
Signature	
Date	

\* If, under the service level agreement dental CBCT images will be reported on by the referring practice, this fact should be recorded here. The referring practice will then be responsible for ensuring the clinical evaluation takes places and is properly recorded.

On completion, retain this form and return a copy to the referring practice.