watersidedentalcare

Referring clinicians are requested to fill in all the fields please

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Cone Beam CT: Imaging Referral Form

Dental Cone Beam CT Imaging Referral Form - £175 Per Scan

Patient details			
Name		Date of birth:	
Address			
Contact tel.	H:	W:	M:
Email:			

Referrer details	
Name	
GDC Number:	
Address	
Signature	
Date of referral	
Referrer contact tel.	
Email:	

Diagnostic (Scan £169)				
Reason for Scan	**Implants** ☐	**Endodontic** ☐	**Assess 8's** ☐	**Other** ☐
Clinical context for requesting a dental CBCT examination				
Which jaws would you like to be scanned?	**Maxilla** ☐	**Mandible** ☐	**Both (Cost still £175)** ☐	**Sectional** ☐
When would you like the patient to be scanned?	**ASAP** ☐		**W/B ..... / ..... / .....**	
Define the anatomical area that the scan should cover				
Do you require this patient to wear a radiographic stent?	**No** ☐	**Yes** ☐	(if so please inform patient to bring it with them)	

Report of scan	**I will arrange my own report** ☐	**I require a report from JMRadiology** ☐	**Sectional £105** ☐	**Single Arch £135** ☐	**Both Arches £165** ☐
Payment Method	**Invoice to clinician** ☐			**Patient to pay** ☐	

For scanning centre use only:

Justification	
Name of IRMER17 practitioner	
Signature	
Date	
Details of scan authorised	
Scan information	
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.