WOODBURY DENTAL AND LASER CLINIC

ESTABLISHED 1980

ULTIMATE IN DENTAL AND MEDICAL AESTHETICS

CBCT Scan Referral Form

Patient Details

Title	First Name	Surname	Date of Birth

Address	
Home ☎	Work ☎
Email Address	Mobile ☎
The clinical context for requesting a dental CBCT examination	
Define the anatomical area that the scan(s) should cover	

18 17 16 15 14 13 12 11	21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41	31 32 33 34 35 36 37 38

Relevant results of history, clinical examination and other imaging

What information do you want the dental CBCT examination to provide?

Is the patient wearing a stent?

Referring Dentist Details

Name.....Title..... Telephone number.....

Address.....

..... email.....

Signature.....Date.....

Single Jaw Scan £99.00
Both Jaws £199.00
Return by E-mail to: vjv@ccrd.net
Or Mail to:

149 High Street, Tenterden, Kent. TN30 6JS. Tel: 01580762323

Will you be reporting the CBCT yourself Yes / No (see service level agreement)

If you need a report there will be an additional fee of _____

Appointment Date..... Appointment Time..... Confirmed Y / N

Justification

Name of IRMER practitioner:

Signature:

Date:

Details of scan authorised

Scan information:

Name of operator

Signature:

Date of scan:

Exposure factors used:

Clinical evaluation (Reporting)*

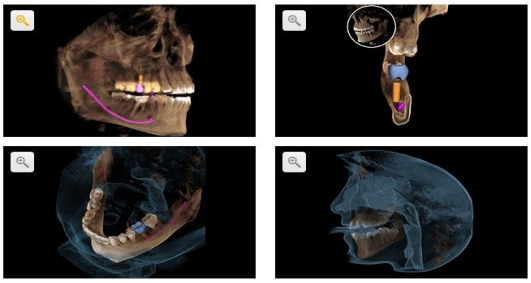
Name of Operator (Reporting)*

Signature:

Date:

Outcome:

** 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 place and is properly recorded.*



Notes