

To make a referral, please complete the form below and save it to your computer before attaching it and sending to Barnton Dental by email at info@barntondental.com.

***Please note**, if you are using Chrome as your browser, you must click 'print' and then 'save as PDF' before attaching to an email.

If you have any issues entering information and saving the form, please download the PDF and then upload to www.pdfescape.com - you will be then be able to complete the fields and then save the document.

Alternatively, you can also simply post a completed form to: Barnton Dental, 461 Queensferry Road, Edinburgh, EH4 7ND.

PATIENT DETAILS

Name:

Date of Birth:

Contact Tel No:

Address:

REFERRER DETAILS

Name:

Date of Referral:

Contact Tel No:

Address:

Email:

REFERRAL DETAILS

The clinical context for requesting a dental CBCT examination:

Define the anatomical area that the scan should cover:

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

REPORTING OF SCANS

Please tick which of the following applies:

I am the IRMER referrer only. I wish Barnton Dental to provide me with a report on my patient's scan.

Please confirm what radiographs you are submitting with this cone beam request:

I am the IRMER referrer/operator. I am adequately trained to report on my patient's scan.

Please confirm how you will be sending in the radiographs:

Email

Post

TO BE COMPLETED BY BARNTON DENTAL

JUSTIFICATION

Name of referrer / practitioner:

Details of scan authorised:

Date:

SCAN INFORMATION

Name of operator:

Exposure factors used:

Date of scan:

CLINICAL EVALUATION (REPORTING)*

Name of operator reporting:

Outcome:

Date:

*If under the Service Level Agreement dental CBCT images will be reported 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.

**ON COMPLETION, RETAIN THIS FORM AND
RETURN A COPY TO THE REFERRING PRACTICE**