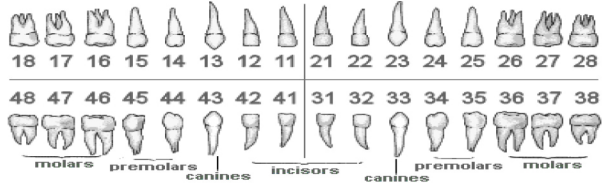


### CBCT - REFERRAL FORM

Please make a referral by completing the form below and sending back to us using the contact details above.  
You can also book online via our website. If you have any questions, please feel free to give us a call on 01932 620200

PATIENT DETAILS		REFERRING DENTIST DETAILS	
Name		Name	
DOB		GDC No.	
Address		Practice address	
Telephone/mobile		Telephone	
Email		Email	
		Signature	

#### SCAN DETAILS

Type of Scan	<input type="checkbox"/> Cone Beam CT	<input type="checkbox"/> OPG/OPT
Scan Size (please indicate area on Diagram)	<input type="checkbox"/> Maxilla (8 x 6) <input type="checkbox"/> Mandible (8 x 6) <input type="checkbox"/> Sextant (4 x 6) (if no teeth specified, full jaw will be scanned)	
CBCT Output Format	<input type="checkbox"/> DICOM file	<input type="checkbox"/> OnDemand3D software
Justification for scan		
Scan template to be fitted	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I will provide my own radiographic report	<input type="checkbox"/> Yes	<input type="checkbox"/> No

#### FEES (£125 per arch/sextant for CBCT and £50 for OPT)

Please indicate who will pay for scan	<input type="checkbox"/> Patient	<input type="checkbox"/> Referrer
For scan 4 x 6 (plus cost of report)	<input type="checkbox"/> £125	<input type="checkbox"/> £ 75 (report)
For scan 8 x 6 (plus cost of report)	<input type="checkbox"/> £125	<input type="checkbox"/> £ 100 (report)

**Please Note:** It is the referring practitioner's responsibility to ensure that all scans and radiographs are reviewed and reported appropriately in the clinical records, in compliance with IRMER 2000 regulations.

It is strongly recommended that all scans/radiographs are reported upon by an appropriately trained individual to assess for any coincidental pathology.

Please let us know if you wish to make your own arrangements for the reporting.