Cone Beam CT: Imaging Referral

For information about how we will use your personal details please see our Practice Privacy Notice

Patient's Details

Patient's Full Name

Patient's Date of Birth

Patients Address

Patient's Postcode

Patient's Email

Patients Phone Number

Referring Dentist's Details

Name of Dentist

Dentist's Phone Number

Practice Address

Practice Postcode

Referring Dentist's Email Address

Cone Beam CT: Imaging Referral

Referring Details

Clinical context for requesting a dental CBCT examination

Relevant results of history, clinical examination and other imaging

What information do you want the dental CBCT examination to provide

Define the anatomical area that the scan(s) should cover

Justification

Name of IRMER17 practitioner

Details of scan authorised

Signed

Dated

Scan information

Cone Beam CT: Imaging Referral

Name of operator

Signature

Date of scan

Exposure factors used

Clinical evaluation (reporting)*

Name of operator (reporting)

Signed

Dated

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 places and is properly recorded.

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