aspects dental & referral

CBCT REFERRAL FORM

Details of Referrer

NAME OF REFERRER	GDC NUMBER
PRACTICE NAME	
ADDRESS	
PHONE NUMBER	EMAIL

Patient Details

TITLE	FIRST NAME	LAST NAME
PDRAATCE TOICFE B NIRATMHE		TELEPHONE
EMAIL		RELEVANT MEDICAL HISTORY

POSSIBILITY OF PREGNANCY YES ☐ NO ☐

HOW WOULD YOU LIKE TO RECEIVE THE SCAN? DROPBOX ☐ USB ☐

HAS THE PATIENT BEEN INFORMED OF THE COST OF THE SCAN? YES ☐ NO ☐

IS THE PATIENT COMING WITH A RADIOGRAPHIC STENT? YES ☐ NO ☐

Which areas would you like the scan to cover?

(if no areas have been selected then then both arches will be scanned i.e. 110x80mm)

MANDIBLE ☐ MAXILLA ☐ BOTH JAWS ☐ WHOLE SINUSES ☐ FLOOR OF SINUS ONLY ☐

UR8	UR7	UR6	UR5	UR4	UR3	UR2	UR1	UL1	UL2	UL3	UL4	UL5	UL6	UL7	UL8
LR8	LR7	LR6	LR5	LR4	LR3	LR2	LR1	LL1	LL2	LL3	LL4	LL5	LL6	LL7	LL8

PLEASE SELECT SCAN SIZE IF KNOWN 40x40mm ☐ 60x60mm ☐ 80x80mm ☐ 110x80mm ☐

WOULD YOU LIKE OUR RADIOLOGIST TO WRITE A RADIOLOGY REPORT OF THE SCAN (£150) TO COMPLY WITH IRMER 2000 REGULATIONS, ALL CBCT SCANS ARE REQUIRED TO BE REVIEWED AND REPORTED. YES ☐ NO ☐

Justification for scan

IMPLANTS ☐ BONE GRAFT ☐ PERIODONTAL ASSESSMENT ☐ POST-OP LOW DOSE ☐

ENDODONTICS ☐ SINUS EXAMINATION ☐ TMJ ASSESSMENT ☐ ORAL PATHOLOGY ☐

IMPACTED TEETH ☐ ORTHODONTICS ☐ OTHER

SUBMITED BY	DATE OF REFERRAL

I confirm that I have received the necessary training to make this referral