CBCT REFERRAL

"(Mandatory)" indicates required fields

Please ensure you complete ALL mandatory fields. Failure to provide details will delay scans.

ACCESSIBILITY *(MANDATORY)*

- [ ] Your patient is able to climb a flight of stairs. Our CBCT machine is located on the first floor.

REFERRING DENTIST DETAILS

DENTIST NAME *(MANDATORY)*

Title | First | Last

GDC NO. *(MANDATORY)*

PREFERRED CONTACT NUMBER *(MANDATORY)*

PRACTICE NAME *(MANDATORY)*

EMAIL *(MANDATORY)*

PATIENT DETAILS

NAME *(MANDATORY)*

Title | First | Last

EMAIL *(MANDATORY)*

DATE OF BIRTH *(MANDATORY)*

PAYMENT OPTIONS *(MANDATORY)*

- ○ Account to referrer
- ○ Patient to pay

ADDRESS *(MANDATORY)*

City | County

Postcode

TELEPHONE NUMBER *(MANDATORY)*

POSSIBILITY OF PREGNANCY *(MANDATORY)*

☐ Yes ☐ No

PURPOSE OF EXAMINATION

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JUSTIFICATION *(MANDATORY)*

- ☐ Implants
- ☐ Impacted teeth
- ☐ Endodontics
- ☐ Sinus exam
- ☐ Bone graft
- ☐ Orthodontics
- ☐ Oral pathology
- ☐ Other

REGION OF INTEREST *(MANDATORY)*

- ☐ Maxilla (single arch)
- ☐ Mandible (single arch)
- ☐ Both arches in single scan, if possible
- ☐ Small Volume (1-3 teeth)
- ☐ Endodontic Scan (1-3 teeth, high resolution +/- 360 degrees)

UPPER JAW

Please specify using the tooth charting, the CBCT area of interest

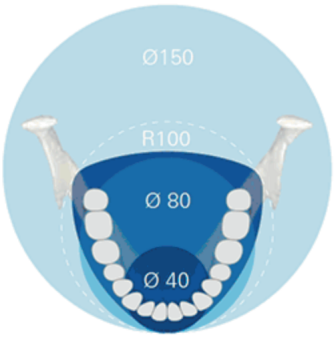
8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

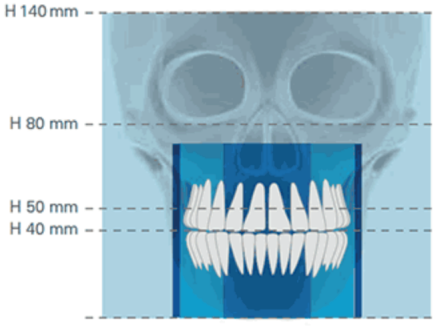
LOWER JAW

Please specify teeth

8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8

FIELD OF VIEW (FOV) AVAILABLE





Please indicate the likely FOV required (width x height mm)

- ○ 40x40 (up to 3 teeth or TMJ)
- ○ 40x80 (up to 3 teeth in opposing arches eg UL6, UL7, LL6, LL7)
- ○ 80x40 (single arch)
- ○ 80x50 (single arch, increased height)
- ○ 80x80 (Both arches if possible, excluding wisdom teeth in larger jaws)
- ○ 100x40 (single broader arch)
- ○ 100 x 50 (Single broader arch increased height)
- ○ 100 x 80 (Both arches, broader view)

This is to ensure you have the required information for your clinical needs and achieved with a dose as low as is reasonably practicable (ALARP). Complying with IMER 2000 and IRR99 regulations.

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DELIVERY *(MANDATORY)*

Select delivery option

- ○ Send me a CD
- ○ Email password protected copy

IRMER 2000 REGULATIONS *(MANDATORY)*

- ○ I would like this patient's radiographic examination to be be reported by your Consultant Radiologist
- ○ I will make my own reporting arrangements

EXTRA INFORMATION

Any other information you would like to supply? e.g. specific imaging parameters / protocols / concerns /FOV considerations / Is the patient attending with a radiographic stent?

PLEASE RETURN THIS FORM BY EMAIL OR POST:

info@wargravedentalclinic.co.uk

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