137 Richmond Road
Kingston upon Thames
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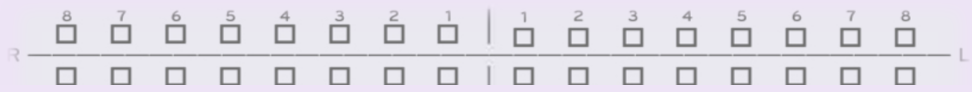
CONE BEAM CT SCAN REFERRAL FORM

Patient information			
Title:	Mr/Mrs/Ms/Other		
Forename(s):		Surname:	
Date of birth:		Possibility of Pregnancy:	
Home Telephone:		Work Telephone:	
Mobile:		E-mail:	
Address:		Post Code:	

Examination Required:

CT MAXILLA CT MANDIBLE BOTH OPG

All images will be taken parallel to the occlusal plane unless you specify a different orientation here:



The clinical content for requesting a dental CBCT:

Relevant results of history, examination and other imaging:

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

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

Patient to wear stent provided by dentist: Yes/ No

It is an IR(ME)R requirement that the reported images must be clinically evaluated, and the findings recorded in the patient's notes. It is also required that the referrer is qualified and trained for this purpose.

Referrer details			
Signature:		Print Name:	
Contact Details:		GDC number:	
Referrer E-mail:		Referrer Tel No:	