**CBCT SCAN**



**REFERRAL FORM**

**REFERRING DENTIST DETAILS**

Full Name: ………………………………………………………………………….... Date Referred: …………………………….….

Address: …………………………………………………………………………………………………………….……………………….……...

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…………………………………………….…………………..…………………………… Postcode: …………………………………...…..

Telephone: ……………………………………..………….. E-mail: …………………………………...…………………...…………..

**PATIENT DETAILS**

Patient’s Name: ……………………………………………………………..…….. Date of Birth: ……………..……..……..…….

Patient’s Address: ……………………………………………………………………………………..…...…………….…………………...

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…………………………………………….…………………..…………………………… Postcode: …………………………………...…..

Home Tel: …………………………………………………… Work Tel: ………………...………………………………………..…….

Mobile Tel: …………………………….…………...……… E-mail: …………………………………...…………………...…………..

**CBCT Digital Panoramic** Maxilla Mandible Sinus

Region of interest and purpose of examination: ..............................................................................................

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**FIELD OF VIEW:** 12 cm x 8.5 cm 8.5 cm x 8.5 cm 8.5 cm x 5 cm 5 cm x 5 cm

**Patient to wear Radiographic Marker?** Yes No

**FORMAT DATA DELIVERY FOR CT SCAN WILL BE BY CD IN POST**

Cirencester Dental Practice does not routinely report upon scans and radiographs. To comply with the IRMER 2000 regulations all radiographs and scans are required to be reviewed and reported into the clinical notes by the referring practitioner or by a radiologist. Cirencester Dental Practice strongly recommends that all CT and other radiographic examinations should be reported upon to rule out the possibility of coincidental pathology. Cirencester Dental Practice offers a reporting service by a Consultant Radiologist at approx. £50. (**PLEASE TICK**):

I would like this patient’s radiographic examination to be reported upon by your Consultant Radiologist.

I will make my own reporting arrangements.

**PAYMENT: Account to Referrer Patient to pay**

**Once completed, please send by FAX to 01285 640258 or**

**EMAIL to** [**reception@cirencesterdentalpractice.com**](mailto:reception@cirencesterdentalpractice.com)

**Please POST the original signed form to:**

**Cirencester Dental Practice**

**The Old Post Office, 12 Castle Street, Cirencester, GL7 1QA**

Tel: 01285 640248 www.cirencesterdentalpractice.com