CHELTENHAM DENTAL SPA

REFERRAL FORM: *X-Rays and CBCT*

PATIENT DETAILS

TITLE

NAME

HOME ADDRESS

DOB (DD/MM/YYYY) TELEPHONE

EMAIL

REFERRING DENTIST DETAILS

TITLE

NAME

PRACTICE NAME AND ADDRESS

GDC NUMBER TELEPHONE

EMAIL

SCAN REGIONS

○ OPT ○ Cone Beam CT Scan

SCAN SIZE (INDICATE AREA ON DIAGRAM BELOW)

○ Mandible / Maxilla (8 x 8) ○ Sextant (5.5 x 5)

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

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

JUSTIFICATION FOR SCAN (MANDATORY)

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SCAN INFORMATION

I confirm I will provide my own Radiographic Report.	◯ Yes	◯ No
Do you have a scan stent to be fitted?	◯ Yes	◯ No

FEES

All fees to be paid at the time of the appointment by the patient, please indicate that you have explained this to the patient	◯ Yes
Scan without report	◯ £95
5.5 x 5 Scan with report	◯ £200
8 x 8 Scan with report	◯ £220

PLEASE NOTE

To comply with IMER 2000 regulations all radiographs and scans must be reviewed and reported into the clinical records by the referring practitioner or by an appropriately trained individual. We strongly recommend that all scans and other radiographic examinations should be reported upon to rule out the possibility of coincidental pathology. If the referring practitioner prefers that they make their own arrangements for the reporting, please let us know in advance.

HOW DID YOU HEAR ABOUT US

DATE (DD/MM/YYYY)