CBCT/OPT REFERRALS:

REFERRING DENTIST DETAILS

Full Name: GDC No: Date:

Address:

Telephone: E-mail:

Please ensure we have your email address to forward digital images and reports.

PATIENT DETAILS

Patient's Name: Date of Birth:

Patient's Address:

Tel: E-mail:

☐ **Digital Panoramic**

☐ **CBCT** **Area/Tooth to be scanned: ……**

FIELD OF VIEW (cm):

☐ 8.0 x 8.0 ☐ 8.0 x 5.0 ☐ 5.0 x 5.0

Patient to wear Radiographic Marker?

Yes ☐ **No** ☐

Radiologist Report Required?

Yes ☐ **No** ☐

REASON FOR REFERRAL (purpose of examination):

……

……

……

……

Referring Dentist Signature: ……GDC No……

Authorised exposure by (for use of One Wood Street):

Signed ……

Costs

OPT £95

CT scans (all sizes) £190

Radiologist Report £80