

CBCT/OPT REFERRALS:

REFERRING DENTIST DETAILS

Full Name: _____ GDC No: _____ Date Referred: _____
 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:

Please note: Should you wish to refer for CBCT we will need a completed Service Level Agreement and evidence of your CBCT level 1&2 training. Contact reception should you wish for this document.

FIELD OF VIEW (cm):
 8.0 x 8.0 8.0 x 5.0 5.0 x 5.0

Patient to wear Radiographic Marker? **Radiologist Report Required?**
 Yes No 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 £120