St James Dental
DENTAL AND COSMETIC CARE
01452 727667

CBCT Referral Form

Patient details

Name: ..... DoB: .....

Address: .....

Contact tel: H: ..... M: ..... Email: .....

Referrer details

Name: .....

Address: .....

Contact tel: ..... Email: .....

Date of referral: .....

Signature: .....

Clinical context for requesting a dental CBCT examination: .....

.....

Relevant results of history, clinical examination and other imaging: .....

.....

please see overleaf

CBCT Referral Form continued...

What information do you want the dental CBCT examination to provide: .....

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

Will a radiographic stent be provided? ☐Y ☐N

In order to comply with the IRMER 2000 regulations, all CBCT scans are required to be reported by the referring practitioner or a radiologist. We recommend that all CBCT images are reported upon to identify any incidental pathological findings. St.James Dental offer a reporting service by a Consultant Radiologist for the sum of £50-£100 (depending on the size of the image).

Would you like this reporting service arranged? ☐Y ☐N

please complete all the the above details prior to sending referral

Justification

Name of IRMER17 practitioner: ..... Date: .....

Details of scan authorised: .....

Signature: .....

Scan information

Name of operator: ..... Date: .....

Exposure factors used: .....

Signature: .....