

3D Cone Beam Scanner Referral Form

Patient's Details:	
Title:.....	PIN:
First Name:	Home Tel:.....
Surname:.....	Work Tel:..
D.O.B:	Mobile Tel:.....
Patient's address:.....	Email:
.....	Preferred contact method:
.....	Notes:
Postcode:.....

Referring Dentist's Details:	
Dentist Name:	Dentist Email Address:.....
Practice Address:	
.....	
Justification for scan:.....	
.....	
.....	
Specific site needed in scan:.....	
Dentist's signature:	
GDC Number:	

Type of scan required and charge	
Child partial	£100 <input type="checkbox"/>
Adult partial	£125 <input type="checkbox"/>
Full upper jaw	£175 <input type="checkbox"/>
Full lower jaw	£175 <input type="checkbox"/>
Full mouth	£200 <input type="checkbox"/>
Payments to be made at the time of scan	

Scans can either be saved onto a disc that includes viewer software, or if required saved as dicom format. Please indicate the format required and whether this should be given to the patient, or returned to the referring clinician.	
Patient <input type="checkbox"/>	Referring clinician <input type="checkbox"/>
Please specify which format you require:	
Galixis viewer <input type="checkbox"/> <small>(Basic viewing software provided)</small>	Dicom format disc <input type="checkbox"/> <small>(If you have your own viewing software)</small>

For Implants only:
All scans will be parallel to the occlusal plane unless otherwise specified
Guide/stent to be worn Yes / No
If you require a guide to be worn during the scan, please ensure the patient is given this and brings it with them to the appointment

Has the patient already had a 2D x-ray before the referral was made Yes No

Please be aware that unless you have had sufficient training you will not be able to justify or report on the CBCT scan therefore please tick one of the boxes below:	
Practitioner suitably trained to justify/report <input type="checkbox"/>	Arrangements made for reporting to be done by a suitably trained person <input type="checkbox"/>
Please give further details:	
.....	