Dentist Referral Form
CBCT-Scan & OPG

Aldgate House
Dental Care

Referring Dentist Details:

Dentist's Name: GDC number:

Practice Name and Address:

Practice Email: Practice Telephone:

Patients Details:

Patients Name: D.O.B: Sex:

Patients Address:

Patient Email: Mob/Tel:

Relevant Medical History (please include known allergies and current medication)

Reason for scan: (mandatory)

Scan Required :

☐ Digital OPT	☐ Mandible
☐ Small Field CT Scan 5x5cm	☐ Both Jaws
☐ Maxilla	☐ CBCT radiologist report (JM Radiology)

Additional Information

☐ I agree to use the referral criteria as per the European Guidelines: Radiation Protection No. 172 and provide adequate clinical information in order for each examination to be justified. I have received adequate training as per HPA-CRCE-010- Guidance on the safe use of Dental Cone Beam CT.

☐ I am acting as the IR(ME)R practitioner and will be justifying my scans I have received adequate training as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT.

☐ I would like my CT Scan to be reported by JM Radiology. The service will be provided by Dr J Makdissi, Consultant in Dental and Maxillofacial Radiology

☐ I will make my own arrangement for the reporting of the CBCT scans acquired at AHDC.

CBCT Output: CD *with VaTechs; Ez3D^{plus}, Ez3Di viewing software, also compatible with any other DICOM viewing softwares*

CBCT Machine: VaTech, PaXi3D Smart

Comments (e.g. area to be scanned, Radiographic Guide etc):

Signature: Date:

* *Check website for prices*

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