



CBCT SCAN REQUEST FORM

CLINICIAN DETAILS

Clinician name	<input type="text"/>
GDC number	<input type="text"/>
Practice name	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Contact Number(s)	<input type="text"/>
Email	<input type="text"/>

PATIENT DETAILS

Title	<input type="text"/>
First name	<input type="text"/>
Surname	<input type="text"/>
Date of Birth	<input type="text"/>
Address	<input type="text"/>
Postcode	<input type="text"/>
Contact Number(s)	<input type="text"/>
Email	<input type="text"/>

RELEVANT MEDICAL HISTORY (please specify medications and allergies)

BRIEF PATIENT HISTORY

CBCT SCAN REQUIREMENTS

Digital OPT (requested with CBCT) - **£30.00**

CBCT - full maxilla - **£150.00**

CBCT - full mandible - **£150.00**

CBCT - full maxilla and mandible - **£200.00**

CBCT - sectional - **£100.00**
please indicate tooth / area for
centre of required small field



CLINICAL JUSTIFICATION FOR CBCT SCAN

REPORTING

The requested CBCT scan is to be reported by the referring clinician.

Is a Consultant Dental Maxillofacial radiologist report required? (additional **£85.00**)

Yes No

Clinician signature _____

Date of referral _____

PAYMENT

Patient at appointment

Invoice referring practitioner

SHARROW VALE DENTAL CARE

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