CBCT SCAN REQUEST FORM

CLINICIAN DETAILS

Clinician name
GDC number
Practice name
Address
Postcode
Contact Number(s)
Email

PATIENT DETAILS

Title
First name
Surname
Date of Birth
Address
Postcode
Contact Number(s)
Email

RELEVANT MEDICAL HISTORY

(please specify medications and allergies)

BRIEF PATIENT HISTORY

CBCT SCAN REQUIREMENTS

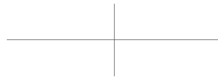
Digital OPT (requested with CBCT) - **£30.00**

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

PAYMENT

Patient at appointment

Invoice referring practitioner

I confirm that the above named patient has consented to onward referral for a Cone Beam CT scan and to being contacted by Sharrow Vale Dental Care.

Clinician signature ______________________

Date of referral ______________

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