SHARROW VALE
DENTAL CARE

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)
- ◯ CBCT - full maxilla
- ◯ CBCT - full mandible
- ◯ CBCT - full maxilla and mandible
- ◯ CBCT - sectional
  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 fee)

◯ 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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