Dental Cone Beam CT Imaging Referral Form for First Choice Dental Practice

Patient details Name: Date of Birth: Address: Patient contact telephone numbers Home: Work: Mobile:
Referrer details: Name: Address: Telephone number: Signature: Date of referral:
The clinical context for requesting a dental CBCT examination:
Relevant results of history, clinical examinationand other imaging:
What information do you want the dental CBCT examination to provide:
Define the anatomical area that the scan(s) should cover:
Justification Name of IRMER practitioner: Signature: Date of scan: Details of scan authorised:
Scan information: Name of Operator: Signature: Date of scan: Exposure factors used:
Clinical evaluation (Reporting): Name of reporting operator: Signature: Date: Outcome:
On completion, a copy of this form will be returned to the referring practice.