

## CBCT REFERRAL

"(Mandatory)" indicates required fields

Please ensure you complete ALL mandatory fields. Failure to provide details will delay scans.

### ACCESSIBILITY (MANDATORY)

Your patient is able to climb a flight of stairs. Our CBCT machine is located on the first floor.

## REFERRING DENTIST DETAILS

### DENTIST NAME (MANDATORY)

<input type="text"/>	<input type="text"/>	<input type="text"/>
Prefix	First	Last

### GDC NO. (MANDATORY)

### PREFERRED CONTACT NUMBER (MANDATORY)

### PRACTICE NAME AND POST CODE (MANDATORY)

### EMAIL (MANDATORY)

## PATIENT DETAILS

### NAME (MANDATORY)

<input type="text"/>	<input type="text"/>	<input type="text"/>
Title	First	Last

### EMAIL (MANDATORY)

### DATE OF BIRTH (MANDATORY)

### PAYMENT OPTIONS (MANDATORY)

- Account to referrer  
 Patient to pay

### ADDRESS (MANDATORY)

### TELEPHONE NUMBER (MANDATORY)

### POSSIBILITY OF PREGNANCY (MANDATORY)

Yes  No

## PURPOSE OF EXAMINATION

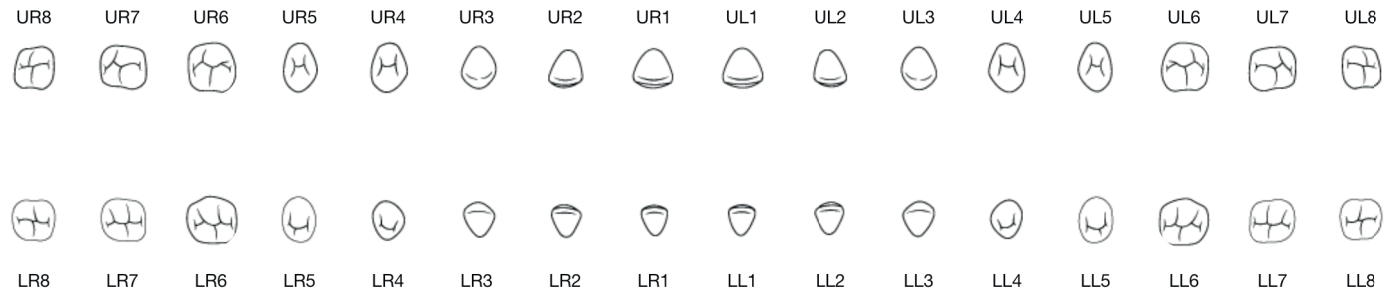
### JUSTIFICATION (MANDATORY)

- Implants
- Impacted teeth
- Endodontics
- Sinus exam
- Bone graft
- Orthodontics
- Oral pathology
- Other

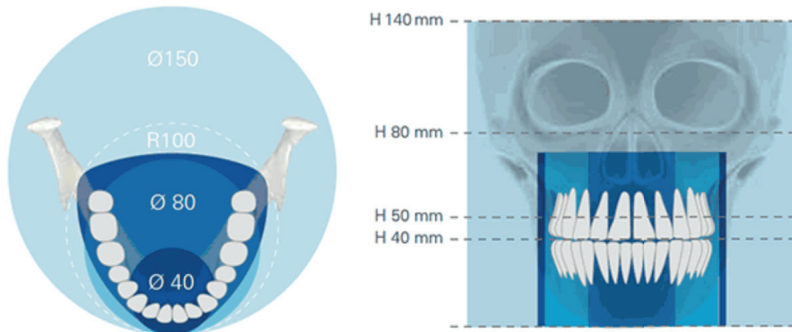
### REGION OF INTEREST (MANDATORY)

- Maxilla (single arch)
- Mandible (single arch)
- Both arches in single scan, if possible
- Small Volume (1-3 teeth)
- Endodontic Scan (1-3 teeth, high resolution +/- 360 degrees)

Please specify using the tooth charting, the CBCT area of interest



### Field of View (FOV) Available



Please indicate the likely FOV required (width x height mm)

- 40x40 (up to 3 teeth)
- 40x80 (up to 3 teeth in opposing arches eg UL6, UL7, LL6, LL7)
- 80x40 (single arch)
- 80x50 (single arch, increased height)
- 80x80 (Both arches if possible, excluding wisdom teeth in larger jaws)
- 100x40 (single broader arch)
- 100 x 50 (Single broader arch increased height)
- 100 x 80 (Both arches, broader view)

This is to ensure you have the required information for your clinical needs and achieved with a dose as low as is reasonably practicable (ALARP). Complying with IMER 2000 and IRR99 regulations.

**DELIVERY (MANDATORY)**

Select delivery option

- Send me a CD
- Email password protected copy

**IRMER 2000 REGULATIONS (MANDATORY)**

- I would like this patient's radiographic examination to be reported by your Consultant Radiologist
- I will make my own reporting arrangements

**EXTRA INFORMATION**

Any other information you would like to supply? e.g. specific imaging parameters / protocols / concerns / FOV considerations / Is the patient attending with a radiographic stent?

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**PLEASE RETURN THIS FORM BY EMAIL OR POST:**

[info@wargravedentalclinic.co.uk](mailto:info@wargravedentalclinic.co.uk)

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