Dento-alveolar CBCT referral request

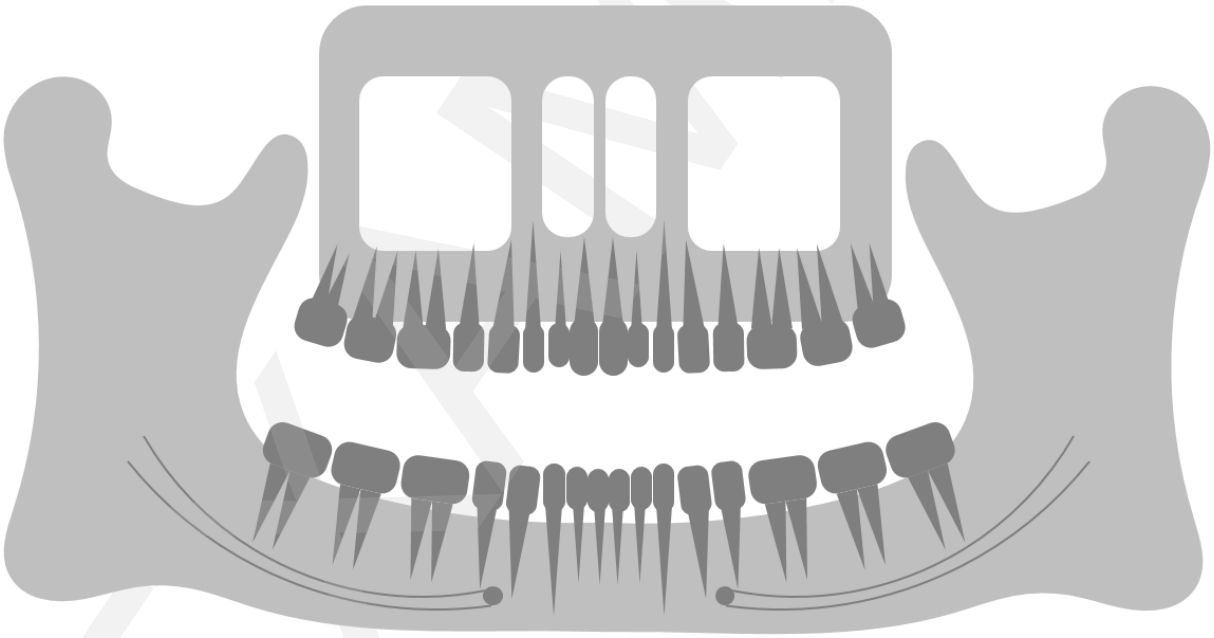
Referral urgency:

Red	Amber	Green
Within 2 weeks	Within 4 weeks	Within 20 weeks

Patient name:
DOB:
Address:
NHS number:
Contact telephone number:

Referring clinician name:
GDC number:
Hospital/practice name:
Contact details (phone/email):

Clinical details relevant to this request:
Relevant dental or medical history:
Relevant previous imaging attached:
Teeth to be included in the scan:
Specific questions you would like answered:
Special requests (e.g. scan with stent in situ):



Please indicated the area you would like scanning:

We offer the following scan volumes - 5x5cm, 6x8cm, 8x8cm and 8x15cm. This request will however be protocoled by our team depending on your request.

Our CBCT scanners are seated or standing (not supine). The patient must stay totally still for up to 30 seconds. If the patient is not ambulatory, able to sit unsupported or weight bear, or unable to stay still for the scan please contact us before hand at the above email address as we may be able to suggest an alternative imaging.

Our roles under IRMER are Practitioner and Operator - radiography. If you require a report please indicate here, and we will also act as Operator - reporting:

Signed: **Date:**