IMPLANT & DENTAL CENTRE

Cone Beam CT: Imaging Referral Form

Patient Details	
Name	
Date of Birth	
Address	
Contact tel	H: M: W:
Referrer Details	
Name	
Address	
Signature	
Date of Referral	
Referrer contact tel	

Clinical context for requesting a dental CBCT examination	
Relevant results of history, clinical examination and other imaging	
What information do you want the CBCT examination to provide	
Define the anatomical area that the scan(s) should cover	

Justification	
Name of IRMER17 practitioner	
Signature	
Date	
Details of scan authorised	
Scan Information	
Name of operator	
Signature	
Date of scan	
Exposure factors used	
Clinical evaluation (reporting)*	
Name of operator (reporting)	
Signature	
Date	
Outcome	
*If, under the service level agreement dental CBCT images will be reported on by the referring practice, this fact should be recorded here. The referring practice will then be responsible for ensuring the clinical evaluation takes place and is properly recorded.	

On completion, retain this form and return a copy to the referring practice.

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