DENTAL CBCT REFERRAL FORM

The Riley Dental Studio, 7 Old Road, Barlaston, Staffordshire. ST12 9EQ
☎: **01782 374330** ✉: **info@therileydentalstudio.co.uk**

PATIENT DETAILS:

Patient Full Name: (Mr/Mrs/Ms/Miss/Dr)..

Patient Full Address: ....

....

....

Patient DOB: ..... / ..... / ..... **Tel:** (daytime) .... (evening) ....

Patient E-mail: (optional) ....

RELEVANT MH:

....

....

The clinical context for requesting a dental CBCT examination:	
Define the anatomical area that the scan should cover:	
What information do you want the dental CBCT examination to provide:	

X-rays enclosed/quantities: ❑ PA/s x ____ ❑ BW/s x _____ ❑ OPG x _____

REPORTING OF SCANS:

I am the IRMER referrer only. I request that TRDS provide me with a report on my patients scan ❑

I am the IRMER referrer/operator. I am adequately trained to report on my patients scan ❑

Patient informed of approximate cost: ❑ Yes ❑ No

OTHER RELEVANT INFORMATION/BRIEF TREATMENT HISTORY:

REFERRING DENTIST:

Name: .... **Signature:** ....

Practice Address: ....

....

Tel: (daytime) .... (evening) ....

Date of referral: ..... / ..... / ..... **E-mail:** ....

Thank you for referring this patient. Please include any current radiographs & a completed MH form. We will return the radiographs to you if required on completion of treatment. Unless you have booked an appointment with us on behalf of the patient we will contact them directly to do so.

TO BE COMPLETED BY THE RILEY DENTAL STUDIO

Justification

Name of referrer / practitioner: ....

Date: ....

Details of scan authorised:

Scan Information

Name of operator: ....

Date of scan: ....

Exposure factors used:

Clinical Evaluation (Reporting)*

Name of operator reporting: ....

Date: ....

Outcome:

****IF UNDER THE SERVICE LEVEL AGREEMENT DENTAL CBCT IMAGES WILL BE REPORTED 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 PLEASE RETAIN THIS FORM AND RETURN A COPY TO THE REFERRING PRACTICE