

CBCT Scan request form



Patient details:

Title: _____ First name: _____ Last name: _____

Address: _____ Postcode: _____

Telephone(s): _____

Email: _____ DOB: / /

Referring Dentist details: *N.B Please complete all fields*

Dentist name: _____ Practice name: _____

Practice Address: _____ Postcode: _____

Practice Telephone(s): _____

Practice Email: _____

Reason for scan: (mandatory)

Brief patient history:

Pregnancy status : _____

CBCT scan requirements:

All scans will be parallel to the occlusal plane unless otherwise specified. Standard image resolution will be supplied unless you specifically request high resolution or endo (50x50mm FOV only)

Radio-opaque marker to be worn? Yes No

Field of view:

- Full upper Full lower
- Full upper and lower (80x80mm)
- Full upper & lower including 8's extended view
- Sectional (50x50mm) Please mark area(s) below

8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8

Reporting:

Indicate your preference for radiological interpretation of the dento-alveolar region.

- I would like a Radiologist report by Consultant Radiologist Dr Nicky Lyle who has a special interest in head and neck radiology and has specialist training in Cone Beam CT reporting.
- I undertake to report on the scan as required by IR(ME)R 20002006

Assistance with case planning is available. Price on application.

Dentist signature: _____ GDC Number: _____

CBCT scan charges:

Scan 50 x 50mm	£95
Scan 80 x 50mm	£150
Radiologist report 50 x 50mm	£60
Radiologist report single jaw	£100
Radiologist report both jaws	£150

Total : _____

How would you like your files?

- Flashstick / USB
- Download from Planmeca Romexis cloud service
- I require Romexis software viewer