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

CBCT scan charges:

Scan 50 x 50mm	£95
Scan 80 x 50mm	£150
Radiologist report	£150

Total : _____

How would you like your files?

◯ Flashstick / USB

◯ Download from Planmeca Romexis cloud service

◯ I require Romexis software viewer

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: