CBCT Scan Request Form

Devonshire House
SPECIALISTS IN DENTAL CARE

Patient details:

Title: First name: Last name:

Address:

Postcode:

Tel (h): Tel (w):

Mobile: Email:

Preferred contact method: DOB: / /

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

Dentist name: Practice:

Practice address:

Postcode: Practice tel:

Email:

Brief patient history:

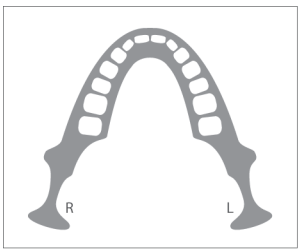
Reason for scan:

CBCT scan requirements:

All scans will be parallel to the occlusal plane unless otherwise specified. Radio-opaque marker to be worn? ◯ Yes ◯ No

Field of View:

- ◯ Full upper ◯ Full lower
- ◯ Full upper and lower (80x80mm)
- ◯ Full upper and lower, inc TMJ (80x150mm)
- ◯ Sectional (50x50mm) Please mark area(s) on diagram below



CBCT scan charges:

Scan		£110	
Radiologist report:	Single jaw	£ 90	
Radiologist report:	Both jaws	£140	Total £

Dentist signature:

GDC number:

STANDARD IMAGE RESOLUTION WILL BE SUPPLIED UNLESS YOU SPECIFICALLY REQUEST HIGH RESOLUTION OR ENDO (50X50mm FOV only)

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

◯ Please supply a Radiologist report OR ◯ I undertake to report on the scan as required by IR(ME)R 2000/2006

Reformatting: Reformatting referral service to IDT Ltd. Price on application.
Assistance with planning: Assistance with case planning at Devonshire House. Price on application.

YOUR PATIENT WILL BE ASKED TO PAY FOR THEIR SCAN AT THEIR APPOINTMENT UNLESS YOU INSTRUCT US OTHERWISE.

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