Corner House Dental Practice
47 High Street
Battle
East Sussex
TN33 0EE

OPG/CEPH CONE BEAM CT SCAN REFERRAL FORM

Patient Details:

Name: _____ **DOB** _____

Address: _____

_____

Tel no (Home) _____ **Mobile** _____

Patient Referral for: (Please TICK) the costs of the scan will be charged directly to the patient

- ☐ £75 Soft copy only
- ☐ £85 Soft copy and photo paper print out

Conebeam CT scan (CD included) Small area 3-5 teeth in jaw

- ☐ £100 endodontic scan
- ☐ £150 Maxilla /Mandible
- ☐ £100 Radiographic evaluation of the exposure and finding.

Email _____

Will the patient bring radiographic stent/guide? YES NO
(Please ensure the patient is given the stent /guide prior to their scan appointment, otherwise a scan will not be done)

Reason for OPG/CEPH/CT SCAN (as required by IRME 2000 guidelines:

_____
_____
_____

Raw DICOM scanning will be returned to you via a CD ☐ with basic viewing software ☐, which will produce a 3D image.

Name of Referring Dentist: _____**GDC Number:** _____
Referring Practice Address: _____
_____
Telephone Number: _____
Dentist Signature: _____ **Date:** _____

Please note: The results of the CT scan will not be medically evaluated by Corner House Dental Team (Unless the report was requested). You will be required to do this and to treat your findings accordingly.

For Our Records:

Date Received	Date Pt contacted	Apt booked	Discharge date