CBCT Referral Form



REFERRER DETAILS		PATIENT	DETAIL	S	DENTIST	TRY & AESTHETICS	
Name of Referrer:		Name of	Patient:				
Practice Name:		Date of E	Birth:				
Address:		Address:					
Telephone:							
Email:		Telephor	ne:				
CLINICAL INDICATIONS (Please Complete)							
							-
Referrer Signature:	M	andible		Maxilla	B	oth Jaws	
JUSTIFICATION FOR X-RAYS	ι	UPPER RIGHT			UPPER LEFT		
Digital Panoramic	on an I	A A M	A (1	A A A	/\ n	A AM MA am	
Implants	AMI	AAF	AA	AIA	BA	AMMA	
Bone Graft	18 17 1	6 15 14	13 12	11 21 22	2 23 24	25 26 27 28	
Impacted Teeth		0 19 14	10 12	11 21 22	20 24	20 20 21 20	
Endodontics	48 47 4	6 45 44	43 42	41 31 32	2 33 34	35 36 37 38	
Sinus Exam	ame	000	00	000	00)
TMJ	MMI	DOA	VV	NAA	VV	A MM M	
Oral Pathology	17	OWER RIC	LUT		LOVAZ	R LEFT	
Ortho	L\	JAAEK KIC	וחכ		LOYVI	CK LEFT	
PAYMENT BY: Referrer Patient	Is the patient coming with Radiographic Stent Yes No						lo
PAYMENT BY: Referrer Patient COST: CBCT Single Arch £150, CBCT Both Arches £300, iTero Scan both Arches £150	Is the pati	ient possil	bly pregi	nant?		Yes N	lo
		11011	18	lens	Katherine C	8	74
Please select your preferred CBCT format: DICOM CT VIEWER iTERC	SCAN		A Pontural Rd	Wishiok Gardens Hanover Gar	Cleves Walk	Fancoput	remean Rd
File delivery options:				or Carde	Fainop	co Rd	

Bluebell Dental Practice and Clinic do not routinely report on CBCT scans. To comply with the IRMER 2000 regulations all CBCT scans are required to be reviewed and reported in the clinical notes by the referring practitioner or by a radiologist.

To Referrer

USB Stick

Dropbox

WeTransfer

140 Tomswood Hill, Chigwell, Essex, IG6 2QP

Tel: 020 8500 6789

To Patient

Email

e-mail: chigwell@bluebelldp.co.uk

www.bluebelldp.co.uk

