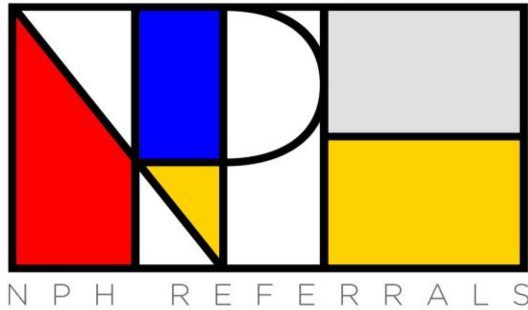

Dental Cone Beam Imaging referral Form - NPH Referrals

Patient details

Name : Date of birth:

Address:

Patient contact telephone numbers : H: W: M:

Referrer details

Name :

Address:

Signature:
Date of referral:
Referrer contact number:

The clinical context for requesting a dental CBCT examination

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Relevant results of history, clinical examination and other imaging

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What information do you want the dental CBCT examination to provide?

Define the anatomical areas that the scan(s) should cover

Justification:
Name of IRMRR practitioner:
Signature:
Date:
Details of scan authorised:

Scan information:
Name of operator:
Signature:
Date of scan:
Exposure factors used:

Clinical evaluation (reporting)*
Name of Operator (reporting):
Signature:
Date:
Outcome:

If, under the Service Level Agreement dental CBCT images will be reported on by the referring practice. This should be recorded here. The referring practice will then be responsible for ensuring the clinical evaluation takes place and is properly recorded