Dental CBCT Referral Form

Market Place Dentistry

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Patient's Details

Title | Name | DoB

Address first line

Postcode | Email

Mobile | Other phone

Referring Dentist's Details (IRMER referrer)

Name | Practice

GDC No

Clinical Details

Field of View

- ○ Small Field — 5 x 5 cm
- ○ Full Upper Jaw — 8 x 5 cm
- ○ Full Lower Jaw — 8 x 5 cm
- ○ Both Upper and Lower Jaws — 9 x 8 cm

For small FoV, please specify the area required

☐ Endo HD *(High resolution for small FoV images only, not available for full jaw views. Gives higher dose, not usually justified for surgical/implant)*

Report required ○ Yes ○ No

☐ *Patient has a radiographic stent to wear during scan*

Fees for scans and reports are available at www.marketplacedentistry.co.uk/cbct-referrals. When your patient attends for their scan, we will take payment from them for the scan and report (if requested). Please let them know to expect this

Clinical reason and justification for scan *(please include proposed positions of any dental implants, if planned)*

I confirm that I have completed training to the appropriate level as described in the FGDP publication '***Guidance Notes for Dental Practitioners on the Safe use of X-ray Equipment***' (available online). If I have not requested a report, I understand that I am responsible for completing or commissioning a report myself

Sign | **Date**

If you're sending this electronically, you can type in your name

After saving, submit online at www.marketplacedentistry.co.uk/cbct-referrals or print and send to us by post

Print

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