Chrysalis Dental Practice & Implant Centre

Patient Name	NHS Number	
Address Post Code	GP Name GP Practice Post Code	
Date of Birth		
Contact Number		
Sex Male ☐	Female ☐	

REFERRER DETAILS

Name:
Address:
Signature:

Date of referral:
Referrer contact telephone number:

SIZE OF CBCT SCAN REQUIRED

4'4 (£110)		6'6 (£200)		8'8 (£250)		110'8	

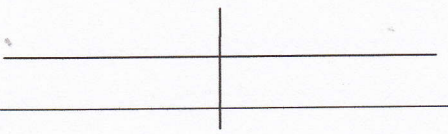
ARCHES REQUIRED:

SINGLE ARCH		DUAL ARCH		

RESOLUTION OF CBCT SCAN(S):

HIGH		MEDIUM		LOW		

ANATOMICAL AREAS THE SCAN(S) SHOULD COVER

Upper	Lower
	

CLINICAL CONTEXT FOR REQUESTING A CBCT EXAMINATION:

RELEVANT RESULTS OF HISTORY, CLINICAL EXAMINATION AND OTHER IMAGING

WHAT INFORMATION DO YOU WANT THE CBCT SCAN TO PROVIDE

JUSTIFICATION:
NAME OF IRMER PRACTIONER:
SIGNATURE:
DATE:
DETAILS OF SCAN AUTHORISED:

SCAN INFORMATION:
NAME OF OPERATOR:
SIGNATURE:
DATE OF SCAN:
EXPOSURE FACTORS USED:
KV:
NA:

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 fact should be reported here. This practice will then be responsible for ensuring the clinical evaluation takes place and is properly recorded*

ON COMPLETION, RETAIN THIS FORM AND RETURN A COPY BACK TO THE REFERRING PRACTICE