GIPSY LANE
ADVANCED DENTAL CARE

CLINICAL REQUEST FORM FOR DENTAL CT SCAN / OPG

Patient Details (Please use BLOCK capitals)

Mr ☐ Mrs ☐ Ms ☐ Other ☐ _____

Surname: _____

Forename(s): _____

Address: _____

_____ Postcode: _____

Date of Birth: _____

Home Telephone: _____

Work Telephone: _____

Mobile: _____

E-mail: _____

Possibility of pregnancy: Yes / No

Examination Required (Please tick √)

CT MAXILLA ☐ CT MANDIBLE ☐ BOTH ☐ OPG ☐

All images will be taken parallel to the occlusal plane unless you specify a different orientation here:

_____

	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	
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	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8	

It is an IR(ME)R requirement that the Referrer provides sufficient clinical information for the x-ray procedure to be justified. Please provide a brief clinical history and state the questions that the OPG or CBCT examination is designed to answer.

_____

_____

Patient to wear stent provided by dentist: Yes / No

All CBCT's will be sent with Invivo Dental Viewer and DICOM images put on to a disc clearly labelled with the patients name and the area scanned.

It is an IR(ME)R requirement that the images must be clinically evaluated and the findings recorded in the patient's notes. Please state who will be doing this:

_____

Referrer Details (*Must be completed)

Signature*: _____ Print Name*: _____

Contact Details: _____

Referrer E-mail: _____ Referrer Tel No: _____

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