GIPSY LANE
ADVANCED DENTAL CARE

CLINICAL REQUEST FORM FOR DENTAL CT SCAN / OP

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	

The clinical content for requesting a dental CBCT:

Relevant results of history, examination and other imaging:

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

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

Patient to wear stent provided by dentist: Yes / No

It is an IR(ME)R requirement that the reported images must be clinically evaluated and the findings recorded in the patient's notes. It is also required that the referrer is qualified and trained for this purpose. Please confirm here by entering NAME and GDC number and SIGNATURE below.

Referrer Details (*Must be completed)

Signature*: _____ Print Name*: _____

Contact Details: _____ GDC Number: _____

Referrer E-mail: _____ Referrer Tel No: _____

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