CBCT Referral Form

Patient Details

Title

First Name

Last Name

DOB

Address

Tel

Email

Referring Dentist Details

Dentist Name

Practice Name and Address

Practice email

Practice Tel

Reason For Referral For CBCT Scan

CBCT Scan Requirements

- [ ] Full upper arch
- [ ] Full lower arch
- [ ] Full upper and lower arches

Sectional Scan – please mention teeth required

Note on IRMER Regulations

IRMER regulations require all radiographs and scans to be reviewed and reported by the referring practitioner or a radiologist. We do not report on the c scans but can arrange for it to be reported by a radiologist at additional cost, or you can send the scan to the radiologist yourself.

Please confirm your preference below – it is COMPULSORY to express a preference.

[ ] I agree to evaluate and report on the scan as required by IRMER regulations

[ ] Please send to radiologist for report with additional charge of £125 per jaw

I have confirmed my preference for reporting on the scans in accordance with IMER regulations.

Dentist Signature_____

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