NORFOLK DENTAL SPECIALISTS
Life-transforming dentistry

CBCT & IMAGING REFERRAL FORM

Date of Referral

PATIENT DETAILS

Name | Date of Birth

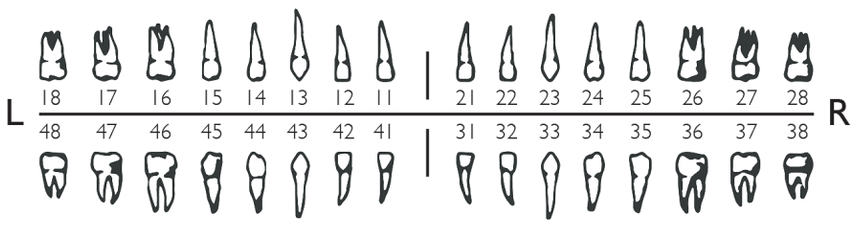
Address

Postcode

Contact Telephone | Email

REFERRAL DETAILS

Please circle the area of interest



Volume of Scan *(please tick)*

2D ☐ DPT

3D ☐ 6 x 4 ☐ 6 x 8

The clinical context for requesting the scan, including justification:

Are there relevant radiographs of the area?
☐ Yes *(please enclose)* ☐ No

☐ Implants ☐ Bone graft
☐ Endodontics ☐ Sinus exam
☐ Extraction ☐ Orthodontics
☐ Oral Pathology ☐ Impacted teeth

REPORTING OF SCANS

Please tick which of the following applies to you:

☐ I am the IRMER referrer only. I wish NDS radiologist to provide me with a report on my patient's scan. I have advised my patient that the fee will be £255.

☐ I am the IRMER referrer / operator. I am adequately trained to report on my patient's scan. I have advised my patient that the fee will be £115.

REFERRER DETAILS

Name | Practice

Address

Postcode

Contact Telephone | Email

Signature | GDC No.

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