CBCT Referral Form

Rose Garden Dental Practice
280 Church Lane
Kingsbury, London
NW98LU

rosegardendentalpractice@gmail.com

rosegardendental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above

If you have any questions, please feel free to give us a call on 02082005588.

Patient details:

Name	
DOB	
Address	
Telephone	
Email	

Referring Dentist Details:

Name	
GDC No.	
Practice Address	
Telephone	
Email	

Scan details

Type of Scan	☐ Cone Beam CT	☐ OPG/OPT
Scan Size (please indicate area on Diagram)	□ Sectional □ Quadrant □ Mandible □ Maxilla □ Both Jaws *If no teeth specified full jaw will be scanned	R L ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 8 7 6 5 4 3 2 1 1 2 3 4 5 6 7 8 ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ R L
CBCT Output Format	☐ DICOM File	
Justification for scan		
Patient to wear stent provided by the dentist	☐ Yes ☐ No	
I need a radiographic report	☐ Yes ☐ No Fee: £40.00	
Scan Resolution	☐ Low ☐ Medium ☐ High	

Fees: CBCT – Maxilla and Mandible: £150 CBCT – Single Jaw/Sectional: £120 CBCT Report: £40
OPG – Maxilla and Mandible: £90 OPG – Single Jaw/Sectional: £50 OPG Report: £40

Please indicate: ☐ Patient to pay at visit ☐ Practice to pay fees

Signature of referring dentist:

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Please note:

- It is Important that you complete all the information of this form in full.
- All incomplete forms will be returned to the referring dental practice, which may result in a delay in your patients' treatment.
- The CBCT image will be reported on by the referring dentist as per your service level agreement – we can arrange for an outside source to report on findings at additional cost.
- The referring practice will be responsible for ensuring the clinical evaluation takes place and is properly recorded