Perlan
Specialist Dental Centre

Perlan Specialist Dental Centre Dental Cone Beam CT Imaging Referral Form

This form can be faxed to 01323 432193 or emailed to care@perlan.co.uk

Patient details

Name: Date of Birth:

Address:

Patient contact telephone numbers: H: W: M:

Referrer details

Name: GDC / GMC number:

Address:

Contact telephone numbers: W: M:

Signature: Date:

Referral:

Clinical reason for requesting a dental CBCT examination:

Relevant history, results of clinical examination and other imaging:

What information do you want the dental CBCT to provide?

Define the anatomical region to be included in the scan:

Should a template be worn: Yes / No (please circle)

Perlan SDC use only

Justification:

Name of IRMER Practitioner:

Details of scan authorised:

Signature: Date:

Scan information:

Name of operator:

Exposure factors used: Volume: kV: MA: Time:

Signature: Date:

Reporting:

Name of operator (reporting):

Report:

Signature: Date:

**If the images will be reported on by the referring practice, this fact should be recorded here. The referring practice will then be responsible for ensuring the clinical evaluation takes place and is recorded.*

ON COMPLETION, SCAN THIS FORM INTO THE PATIENT'S NOTES AND RETURN A COPY TO THE REFERRING PRACTICE WITH THE SCAN