Newcastle Dental & Implant Clinic

CBCT REFERRAL FORM

Referred by:
Address:

Telephone:

Patient Name: **DOB:** **Pt code:**

Address: **I have quoted: £**
Contact telephone numbers: (M)

Clinical context for requesting a dental CBCT examination:

Relevant results of history, clinical examination and other imaging:

What information to you want the CBCT examination to provide:

Define the anatomical area the scan should cover:

Justification
IRMER Practitioner:
Signature:
Date:
Details of scan authorised:

Scan Information
Operator:
Signature:
Date of scan:
Exposure factors used:

Clinical Evaluation (Reporting):
Operator (Reporting):
Signature:
Date:
Outcome:

On completion retain this form and return a copy to the returning practice