MONA LISA SMILES
OUR REPUTATION LIES WITHIN YOUR SMILE

CBCT Scan Referral Form

All the information you provide here is kept strictly confidential

Patient Details

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr ☐ Prof ☐ Rev ☐ Other:_____

Patient Name:_____ **Gender:** **Male** ☐ **Female** ☐

Date of Birth: _____ **Email:** _____

Home Tel: _____ **Mobile:** _____

Address: _____

_____ **Postcode:** _____

Is patient possibly Pregnant? **Yes** ☐ **No** ☐

Referred By

Practitioners Name: _____ **Telephone:** _____

Practice: _____ **Email:** _____

Address: _____

_____ **Postcode:** _____

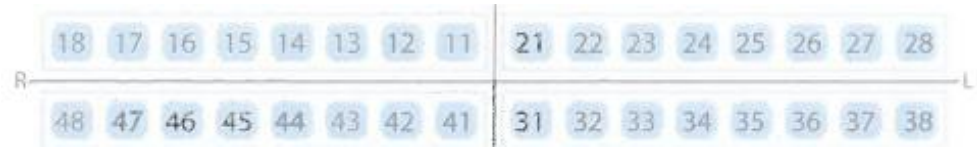
Referred By

Please select tooth/teeth by ticking the numbered boxes below:

Maxilla (Upper Jaw)

Mandible (Lower Jaw)

Both Jaws (Do not select tooth regions)



Teeth Region (quadrant) (Please draw a circle around region of teeth)

Reason for Scan: _____

Provide additional scan info: _____

Is patient arriving with a radiographic guide/template? ☐ **Yes** ☐ **No**

Scan output

Type of scan ☐ **3D** ☐ **2D Digital Panoramic (OPG)**

CT Scan output format:

☐ **CD with 3D x-ray viewer software** ☐ **Hard Copy (Image)** ☐ **DICOM Files (Email or web link)**

☐ **Email or web link to 3D x-Ray viewer software** ☐ **Email attachment (Jpeg Image)** ☐ **Radiology Report**

Payments

Payment from ☐ **Doctor** ☐ **Patient**

Signature: _____ **Date:** _____

Regulations

To comply with the IRMER 2000 Regulations, all radiographs and scans are required to be reviewed and reported into clinical notes by the referring practitioner or radiologist.

☐ **The patients medical history record is attached to this form and is to be reported by your radiologist**

☐ **I will make my own reporting arrangements**