Elvetham
Dental Implants, Imaging & Cosmetic Solutions

CBCT Referral Request Form

APPOINTMENT DETAILS

If you wish to arrange an appointment on the patient's behalf, please telephone the clinic on 01252 620500. Once an appointment has been arranged, enter the details below:

Date of appointment: _____ Time of appointment: _____

PATIENT DETAILS

Title: _____ First name: _____
Surname: _____
DOB: _____
Address: _____
_____
_____
Tel (home): _____
Tel (work/mobile): _____
Email: _____

REFERRING DENTIST DETAILS

Title: _____ First name: _____
Surname: _____
Address: _____
_____
_____
_____
Tel (home): _____
Tel (work/mobile): _____
Email: _____

TYPE OF IMAGE REQUIRED

☐ 3D CT Scan
☐ 2D Panoral

REGION OF INTEREST

☐ Full Image/Both Jaws
☐ Single Jaw
☐ Md/Mx Sectional View (image view contains 3-4 teeth)

Tooth notation

REASON FOR IMAGE REQUEST

☐ Implant Placement
☐ Wisdom Tooth/Teeth Removal
☐ Oral Surgery
☐ Endondontic Assessment
☐ Orthodontic Assessment
☐ Periodontal Assessment
☐ Other (please specify)
_____

Is a radiological report required? (Please note an additional fee applies) Yes ☐ No ☐

Are additional copies of the scan on CD required? Yes ☐ No ☐ If so, how many? _____
(Please note this service is chargeable)

Who is paying for the image(s)? (& report, if applicable) Dentist ☐ Patient ☐

ANY OTHER RELEVANT INFORMATION OR INSTRUCTIONS

DENTIST'S SIGNATURE: GDC REGISTRATION: DATE OF REFERRAL: