

REFERRING CLINICIAN

Name: _____

GDC no: _____

Address: _____

Tel no: _____

Email _____

PATIENT DETAILS

Name: _____

Address: _____

D.O.B: _____

Tel no: _____

Email: _____

PAYMENT DETAILS:

Patient to pay

Account to referrer

I would like the study to be reported on by a consultant radiologist.

I will make my own reporting arrangements.

CLINICAL INDICATION

To comply with IRMER regulations all plan radiographs and CBCT scans must be reviewed and the findings recorded. We recommend that all imaging is reported to exclude coincidental pathology and we offer a Consultant Radiologist reporting service.

Any relevant information:

Signed: _____

Date: _____

Prescription: OPG CBCT

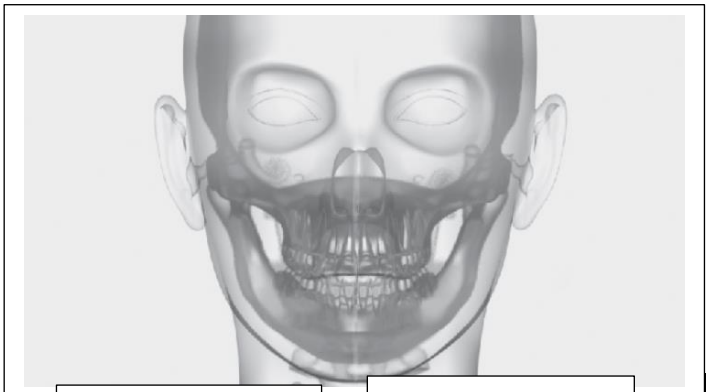
CBCT Area of interest:

Small volume

Upper jaw (full arch)

Lower jaw (full arch)

Upper and lower jaw (both arches)



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 □□□□□□□□

CT images are provided in DICOM format using Planmeca imaging software, if you prefer an alternative viewing system please contact the practice.

CBCT Express
Southgate House, 72 Thornton Road,
Bradford, BD1 2DG

T: 01274 744 744
info@cbctexpress.co.uk