# CBCT SCAN REFERRAL FORM

To make a referral for a CBCT Scan, please complete the form below and save it to your computer before attaching it and sending to Blue Pearl Dental Care by email at: **info@bluepearldental.com**.

If you have difficulty completing this form, please enter data manually, print and post the completed form to: **Blue Pearl Dental Care 126A Seven Sisters Road, London N7 7NS.**

You can complete this form Online.

## Patient Details

**Title:** Mrs **Patient's name:**

**Patient's address:** **Postcode:**

**Date of Birth:**

**Tel:** **Mobile:**

**Email:**

## Referring Dentist Details

**Dentist's name:**

**GDC No:**

**Practice address:** **Postcode:**

**Referral Date:**

**Tel:** **Mobile:**

**Email:**



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# Referring Details

Reason for referral and clinical justification for CBCT scan?

Define the anatomical area that the scan should cover:

What information do you want the dental CBCT examination to provide?

Patient to wear stent provided by dentist? yes or no.

# Referring Details Cont.

OPG or Sectional 3D scan?



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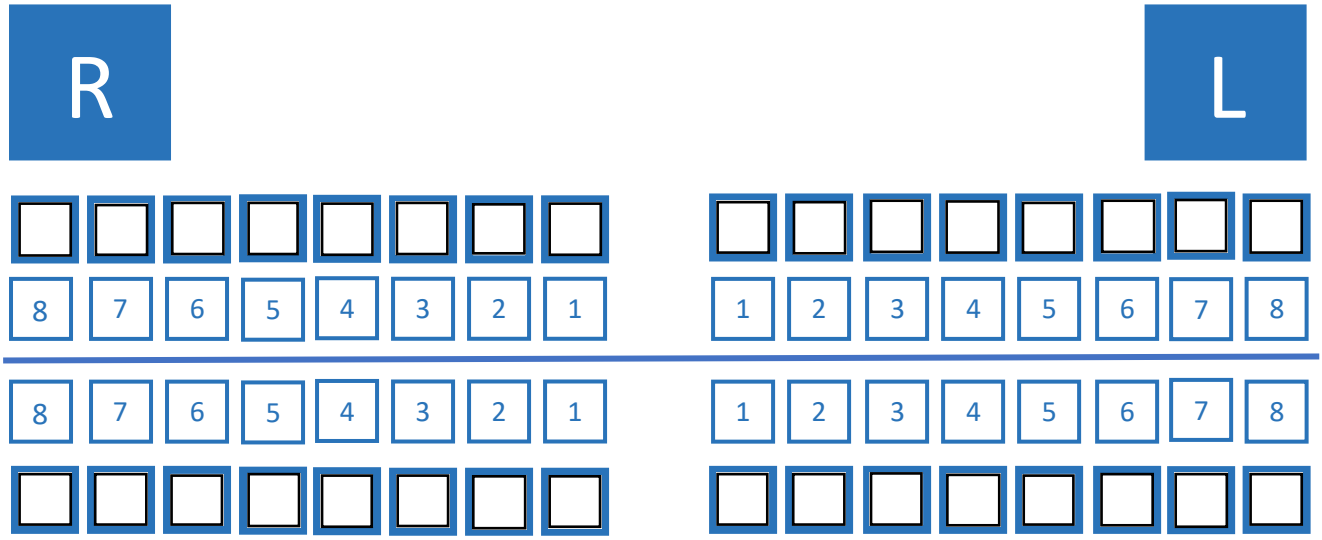
Justification for radiograph (this section must be completed)

Define the anatomical area that you would like the scan to cover.

**Mandible** ☐ **Maxilla** ☐ **Both Jaws** ☐




## Fees

Please refer to the price list below for information on our services

| Service | Price |
|---|---|
| CT Scan per arch | £120 |
| OPG | £60 |
| | |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# Please tell us your preferences

Patients to pay at visit: ☐ OR Practice to pay fees: ☐

**Please Note:**

- Patient is generally given the image data to take away with them on the day - both SI RONA DICOM Export Wrap & Go and/or Raw DICOM data (to be imported into your own CT Viewing software -Simplant. iCat Vision, CS-3D etc.)
- The CBCT image will be reported on by the referring dentist as per your service level agreement - we can arrange for an outside source to report on findings at an additional cost.

**Important information**: it is essential that you complete all sections of this form in full.

***All incomplete forms will be returned to the referring dental practice, which may result in a delay in your patients' treatment.***

The referring practice will be responsible for ensuring the clinical evaluation takes place and is properly recorded.

**Signature of referring dentist:**

☐

If you do not have a digital version of your signature available, please type name in signature area to the Left and check the box above to acknowledge the inclusion of all data required for us to proceed.



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