REFERAL FORM

If you have any queries then please do not hesitate to contact us on **01622741817**

- **Practice Details**

- Practice Name

- Practice Address
  Street Address Address Line 2 City County
  Postcode
- Email*
- Practice telephone*
- **Patient Details**
- Patient Name*
  Prefix First Last

- Patient Address
  Street Address Address Line 2 City County
  Postcode

- Patient Date of Birth
  DD MM YYYY
- Patient Contact Number*
- Patient Email*
- **3D CBCT area of interest**

- Please choose from one of the following:
  - ☐ Both Arches
  - ☐ Mandible
  - ☐ Maxilla

- ☐ Small Field of View - 5x5cm or 8x5cm
- ☐ OPG

- Please stipulate the exact teeth/area you require e.g. "UR4,UR2

- **Justification for scan (IRMER 2000):**

- Please select all that apply from the list below:
  - ☐ Implant treatment planning (assessment of position of anatomical structures, bone quality and quantity)
  - ☐ Orthodontic assessment and planning
  - ☐ Endodontic assessment
  - ☐ Wisdom teeth assessment:
  - ☐ - UR8
  - ☐ - UL8
  - ☐ - LL8
  - ☐ -LR8
  - ☐ TMJ

- Other (Please specify):

- **To be completed by the referring practitioner:**

  This will act as the practitioner's electronic signature: I hereby authorize Orchard Dental Practice, Maidstone to carry out a 3D CBCT on my behalf. When scanning guides are used, these guides will be prepared in advance by the referring dentist and given to the patient to bring to the scan appointment. The results of the scan will be returned in a with basic viewer software. Although an evaluation of the scan will be carried out and a report supplied, I am responsible for assessing the data and referring to the necessary specialties as clinically indicated. Orchard Dental Practice and the Operator will not be responsible for assessing the scan for the suitability of

treatment or for ultimately identifying and referring pathology; by referring the patient I am accepting this responsibility. The HPA CRCE-010 guidelines suggest that attendance of a CBCT Training Certificate Course is deemed a regulatory requirement for all users of CBCT systems, including those who are simply referring patients for acquisition of a CBCT image. I accept that it is my responsibility to obtain the necessary qualification in order to refer and evaluate the data requested by me and provided by Orchard Dental Practice . Alternatively I will arrange for a Consultant Radiologist to rule out coincidental pathology.

- Name of IRMER Practitioner*
  First Last
- GDC Number*
- Additional Comments:
- Reporting:*

  Please select one of the following:
  - I would like my Cone Beam CT to be reported by orchard dental practice . The service will be provided by a suitably trained and qualified member of the clinical team.
  - I will make my own arrangement for reporting of my Cone Beam CT scans acquired at YOUR Centre. This will be done by someone adequately trained as per HPA-CRCE-010 Guidance on the safe use of Dental Cone Beam CT
  - I will report my Cone Beam CT scans acquired at YOUR Centre. I confirm that I am adequately trained to interpret cone beam CT scans as per HPA-CRCE-010 Guidance on the safe use of Dental Cone Beam CT. I will ensure that my training remains up to date.

Your information will be treated in accordance with our privacy policy

Submit

Reporting & scanning fees

Reporting fees:

£60 – Small /single tooth
£75 – Medium/ quadrant
£120 – Large volume full arch

Scanning fees:

£200 – Both arches
£120 – Single arch (maxilla or mandible)
£120 – Smaller field of view where suitable 5×5 cm
£45 – OPG