



Cone Beam CT Imaging Request Form

Patient Details

Name	
Date of Birth	
Address	
Contact Details	Tel: E-mail:

Request and Justification

Clinical justification		
Information required and Anatomical area(s) the scan should cover	<input type="checkbox"/> Patient has a radio-opaque marker to wear	
Resolution of scan	<input type="checkbox"/> Low Resolution <input type="checkbox"/> Standard Resolution <input type="checkbox"/> High Resolution	<i>Information on dose reduction technology can be found at KPTeeth.co.uk/CBCT</i>

Prescribing Dentist Details

Name		
Date of Referral		
Practice		
Address		
Contact Details	Tel: E-mail:	
Image Format	<input type="checkbox"/> DICOM File <input type="checkbox"/> Multifile DICOM <input type="checkbox"/> Image with viewing software <input type="checkbox"/> Cloud storage (secure link emailed) <input type="checkbox"/> CD posted to practice	
Billing	<input type="checkbox"/> Bill patient directly (Please advise of patient £95 charge) <input type="checkbox"/> Invoice to practice	
Signature	<i>The prescribing dentist is required by the Department of Health to have undertaken 'Core Training in CBCT' as outlined in the HPA-CRCE-010 report. The scan will not be reported on and this is the responsibility of prescribing dentist.</i>	

For more information, visit KPTeeth.co.uk/CBCT

Email to: Info@KPTeeth.co.uk **Post to:** 1 Stuart Court, Kingston Park, NE3 2QF