

CT EXAMINATION REFERRAL FORM

PLEASE FAX/POST/E-MAIL TO CHASE LODGE DENTAL IMAGING

PATIENT DETAILS

RELEVANT MEDICAL/DENTAL HISTORY

Name (Mr, Mrs, Ms):

D.O.B:

Address:

Postcode:

Contact Telephone No's:

REFERRING PRACTITIONER DETAILS

Name:

Practice Address:

GDC No:

Postcode:

**Practitioner
Signature:**

Tel:
Mob:
Fax:
Email:

EXAMINATION REQUEST

Please circle the areas for CT Scan:

Left Maxilla

Left Mandible

Right Maxilla

Right Mandible

Complete Maxilla

Complete Mandible

Please tick boxes required:

Sectional scan

Full Jaw Scan

Written report

OPG

It is the responsibility of the referring practitioner if no report is requested to satisfy IRMER 2000 requirements

Imaging Stent supplied by referring dentist?

Y / N

Earliest date for scan:

Region of specific clinical interest:

87654321 | 12345678

87654321 | 12345678

Proposed course of treatment: (Include details of proposed number & location of implants)

To comply with the IRMER 2000 regulations, all radiographs and scans are required to be reviewed and reported into the clinical notes by the referring practitioner or by a radiologist.

I would like to make this patient's radiographic examination to be reported upon by you

I will make my own reporting arrangements

Sectional scan CD only (suitable for implants in one quadrant or anterior segment) £150
Full jaw scan £210 Written report £85 OPG (email or CD) £50