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	[ ] Patient has a radio-opaque marker to wear	
Resolution of scan	[ ] Low Resolution [ ] Standard Resolution [ ] High Resolution	*Information on dose reduction technology can be found at KPteeth.co.uk/CBCT*

Prescribing Dentist Details

Name	
Date of Referral	
Practice	
Address	
Contact Details	Tel: E-mail:
Image Format	[ ] DICOM File [ ] Image with viewing software [ ] Cloud storage (secure link emailed) [ ] CD posted to practice
Billing	[ ] Bill patient directly (Please advise of patient £95 charge) [ ] Invoice to practice
Signature	*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.**

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

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