PANORAMIC X-RAY / CBCT REFERRAL FORM

To make a referral for a Panoramic X-Ray or a CBCT Scan, please complete the form below and save it to your computer before attaching it and sending to Klassdental by email at reception@klassdental.com

If you have difficulty completing this form, please print an empty form, enter data manually then scan and send by email at reception@klassdental.com or post to Klassdental, Unit B Harbour Road, Seaton, EX12-2LS.

PATIENT'S DETAILS

Title:	
Patient's Name:	
Date of Birth:	
Patient's Address:	
Postcode:	
Telephone:	
Mobile:	
Email:	

REFERRING DENTIST'S DETAILS

Dentist's Name:	
GDC number:	
Practice Name:	
Practice Address:	
Postcode:	
Telephone:	
Email:	

RADIOGRAPHIC INVESTIGATION REQUEST:

◯ Digital Panoramic Radiograph (OPG)

◯ 3D Cone Beam CT Scan (please complete mandatory fields below)

REFERRING DETAILS

Reason for referral and clinical justification for CBCT scan?

Define the anatomical area the CBCT should cover:

◯ Full Mouth ◯ Full Maxilla ◯ Full Mandible

◯ Maxilla (Right) ◯ Maxilla (Middle) ◯ Maxilla (Left)

◯ Mandible (Right) ◯ Mandible (Middle) ◯ Mandible (Left)

What information do you want the CBCT examination to provide?

Will the Patient wear stent provided by the dentist?

◯ Yes ◯ No

KLASSDENTAL, Unit B Harbour Road, Seaton, EX12-2LS. Tel: 01297 300 761
email: reception@klassdental.comwebsite: www.klassdental.com

GENERAL TERMS AND CONDITIONS:

Patients are generally given the image data to take away with them on the day (CD/DVD – both export with Acteon AIS viewing software 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. The referring dentist certifies that he/she has the mandatory level of training necessary for prescribing CBCT examinations.

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 the referring dentist

Date:

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