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CBCT Scanning Request Form

Referring Dentist details:

Practice name and address:	
Telephone:	Email:

Patient details:

Name:	
Date of birth:	
Address:	
Telephone:	Email:

This section MUST be completed IN FULL by the referring dentist only

<table>
<tr><td>Reason for referral / Justification for requested image</td><td colspan="2">Implant planning :

Endodontics :

Orthodontics :

Oral surgery :

TMJ:

Other please specify :</td></tr>
<tr><td>Define the anatomical area that you would like the scan to cover.
The 3D scan volume is a cylinder with 50mmx50mm or 80mmx80mm

Please circle the area(s) to be scanned:</td><td colspan="2">
<table>
<tr><td>8 7 6 5 4 3 2 1</td><td>1 2 3 4 5 6 7 8</td></tr>
<tr><td>8 7 6 5 4 3 2 1</td><td>1 2 3 4 5 6 7 8</td></tr>
</table>
Please Tick

OPG 2D ☐

Cone Beam Scan 5x5 for three or four tooth area in a single arch: ☐

Cone Beam Scan 8x8 for both arches to include all teeth: ☐</td></tr>
<tr><td>Referral authorised by:</td><td>I accept that I am responsible for the reporting of this image and it's appropriate management.</td><td>Dentist Name:

Dentist Signature:

Date:</td></tr>
</table>