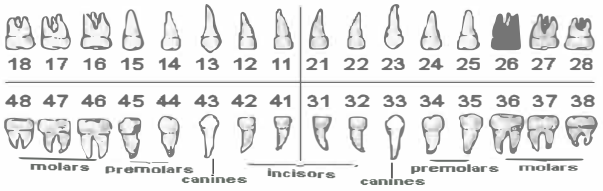
west byfleet
DENTAL & IMPLANT CENTRE
Madeira Road, West Byfleet, Surrey, KT14 6DH | Tel: 01932 620200 | Fax: 01932 989895 | Email: info@westbyfleetdental.co.uk

CBCT - REFERRAL FORM

Please make a referral by completing the form below and sending back to us using the contact details above.
You can also book online via our website. If you have ay questions, please feel free to give us a call on 01932 620200

PATIENT DETAILS	
Name	
DOB	
Address	
Telephone/mobile	
Email	

REFERRING DENTIST DETAILS	
Name	
GDC No.	
Practice address	
Telephone	
Email	
Signature	

SCAN DETAILS		
Type of Scan	☐ Cone Beam CT	☐ OPG/OPT
Scan Size (please indicate area on Diagram)	☐ Maxilla (8 x 6) ☐ Mandible (8 x 6) ☐ Sextant (4 x 6) (if no teeth specified, full jaw will be scanned)	
CBCT Output Format	☐ DICOM file	☐ OnDemand3D software
Justification for scan		
Scan template to be fitted	☐ Yes	☐ No
I will provide my own radiographic report	☐ Yes	☐ No

FEES (£225 per arch/sextant for CBCT and £95 for OPG)		
Please indicate who will pay for scan	☐ Patient	☐ Referrer
For scan 4 x 6 (plus cost of report)	☐ £225	☐ £ 225 (report)
For scan 8 x 6 (plus cost of report)	☐ £225	☐ £ 225 (report)

Please Note: *It is the referring practitioner's responsibility to ensure that all scans and radiographs are reviewed and reported appropriately in the clinical records, in compliance with IRMER 2017 regulations.*

It is strongly recommended that all scans/radiographs are reported upon by an appropriately trained individual to assess for any coincidental pathology.

Please let us know if you wish to make your own arrangements for the reporting.