Rowcroft Dental Centre

11 Rowcroft
Stroud
Gloucestershire
GL5 3AZ

Cone Beam CT Referral Form

Patient details

Name:	DoB: DD / MM / YYYY	Male ❑	Female ❑
Address: Postcode:			
Home Tel:	Work Tel:	Mobile Tel:	

Region requiring imaging:

Image size

5 x 5.5cm	8 x 5.5cm	8 x 8cm

Side of mouth

LEFT	RIGHT

Justification of scan:

Other information

Please describe any mobility or communication issues relevant to the patient's treatment

It is the responsibility of the referring practitioner to ensure the scan is reported on by an adequately trained professional (Dentist or Radiologist). It is important that the whole can area is analysed for incidental findings and pathology. Scan data will be sent to the referring practitioner by post on DVD.

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Name, signature and address of referring dentist

Date: DD / MM / YYYY

Print name:

Signature:

Address:

I can confirm I have undertaken an appropriate dental CBCT course for referrers ☐