NORFOLK DENTAL SPECIALISTS
Life-transforming dentistry

CBCT & IMAGING REFERRAL FORM

Date of Referral

PATIENT DETAILS

Name | Date of Birth

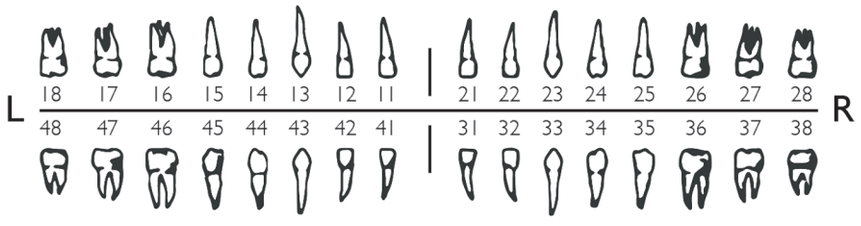
Address

Postcode

Contact Telephone | Email

REFERRAL DETAILS

Please circle the area of interest



Volume of Scan *(please tick)*

- ☐ 2D DPT – £55
- ☐ 3D 8 × 8 – £250 (Upper & Lower Arch)
- ☐ 3D 5 × 8 – £125 (Full Arch)

The clinical context for requesting the scan, including justification:

Are there relevant radiographs of the area?
☐ Yes *(please enclose)* ☐ No

- ☐ Implants
- ☐ Bone graft
- ☐ Endodontics
- ☐ Sinus exam
- ☐ Extraction
- ☐ Orthodontics
- ☐ Oral Pathology
- ☐ Impacted teeth

REPORTING OF SCANS

Please tick which of the following applies to you:

- ☐ I am the IRMER referrer only. I wish NDS radiologist to provide me with a report on my patient's scan. I have advised my patient that the fee will be £135 per report in addition to the scan fee.
- ☐ I am the IRMER referrer / operator. I am adequately trained to report on my patient's scan.

REFERRER DETAILS

Name | Practice

Address

Postcode

Contact Telephone | Email

Signature | GDC No.

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