130 dental | centre

130 Coldharbour Lane, Hayes, UB3 3HB
0208 573 0026
Please email form to: dental.v80726@nhs.net

CBCT REFERRAL FORM

Patient Details

Title: Mr | Mrs | Ms | Miss | Master | Dr | Prof.

First Name: _____

Surname: _____

Date of Birth: _____

Tel (Home): _____
Tel (Work): _____
Tel (Mobile): _____

Email: _____

Address: _____

_____

_____

_____

Referring Practitioner: _____

_____

Practice Name: _____

Address: _____

_____

_____

Telephone: _____

Email: _____

GDC: _____

Additional Comments: _____

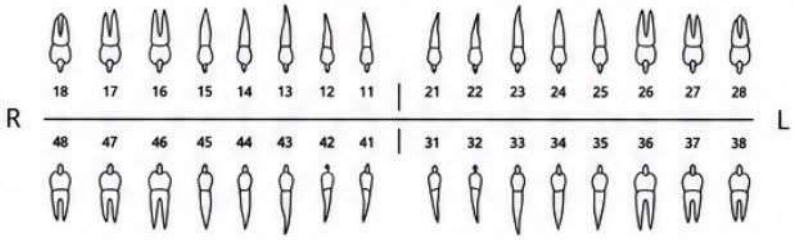
_____

_____

Date: _____

TO BE COMPLETED BY THE REFERRING PRACTITIONER

☐ Mandible ☐ Maxilla ☐ Both Jaws



Is the patient coming with a radiographic stent? ☐ Yes ☐ No

Is the patient possibly pregnant? ☐ Yes ☐ No

CBCT Format: DICOM

Email to: Patient ☐ Referrer ☐

- ☐ Implants
- ☐ Bone Graft
- ☐ Impacted Teeth
- ☐ Endodontics
- ☐ Sinus Exam
- ☐ TMJ
- ☐ Oral Pathology
- ☐ Ortho

Payment: ☐ Referrer ☐ Patient

Scan only from £125 per arch
Reporting fees apply separately.

I confirm that I am a GDC registered practitioner and have the completed this form with correct and relevant clinical information.