

## Dental CT Scan Request Form

### Patient Details

Title:	Initials:	Referral Date:
_____	_____	_____
First Name:	Surname:	
_____	_____	
Address:	D.O.B.:	
_____	_____	
	Home Tel:	
	_____	
Notes:	Work Tel:	
_____	_____	
	Mobile Tel:	
	_____	

### Referring Dentist Details

Dentist Name:	Dentist Email:
_____	_____
Practice Name:	
_____	
Practice Address:	Practice Tel No:
_____	_____
Reason for scan and justification:	
_____	
Dentist Signature:	GDC Number:
_____	_____

*By signing this, I undertake to report on the scan as required by IR(ME)R 2000/2008:*

### CT Scan Requirements

*All scans will be parallel to the occlusal plane unless otherwise specified. Scans are on CD.*

Radio-opaque markers to be worn?	Maxilla <input type="checkbox"/>	Full Arch (FOV 6 x 8 cm) <input type="checkbox"/>
Yes <input type="checkbox"/> No <input type="checkbox"/>	Mandible <input type="checkbox"/>	Small Arch FOV (6 x 4 cm) <input type="checkbox"/>

Centre around which area? \_\_\_\_\_