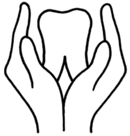

Hospital Lane Dental and Implant Clinic
Lord Lees Grove
Blue Bell Hill
Kent ME5 9PE
Tel: 01634 842566
Email: reception@hospitallane.com
Web: www.hospitallane.com

Referral for Cone Beam CT Imaging

Patients Name: .... D.o.B. ....

Address: ....

....

Telephone No. (H) .... (M) ....

Referring Dentist: ....

Practice Address: ....

....

Email Address*: ....

*The provision of your email address is essential for Dental Imaging Referrals, as panoramic and cephalometric radiographs are returned via email.

Telephone No. ....

The Clinical Context for requesting a cone beam CT i.e. Implant Planning, Oral Surgery ....

What information do you want the Cone Beam CT to provide? i.e. Bone Volume, Bone Density

....

Please indicate which teeth/areas require scanning

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Justification

Name and Signature of IRMER/Referring practitioner: ....

....

Scan Information

Name and Signature of HLDC Operator: ....

Date of Scan: ....

Exposure factors used: ....

Clinical Evaluation (Reporting) The Referring Practice is responsible for insuring the clinical evaluation (reporting) of the CT scan(s) takes place and is properly recorded.

THE CONE BEAM CT IMAGES WILL BE SENT IN DICOM FORMAT ON A DISC TO THE REFERRING PRACTICE WITH A COMPLETED COPY OF THIS FORM TO BE RETAINED IN THEIR RECORDS