

[IMPORTANT] By law the external referring practices must have a written Service Level Agreement with us. If you do not have one, please contact the practice.



CBCT Scan Referral Form

To initiate a referral for a CBCT Scan, kindly fill out the form provided below, save it to your device, and attach it to an email addressed to **reception@thesandford.com**.

In case you encounter any issues while completing this form electronically, please manually enter the required data, print the completed form, and send it via post to the following address: **The Sandford, 306 Broadway, Bexleyheath, Kent DA6 8AA**.

Patient Details

Patient's name

Date of birth

Address

Contact Numbers

Home

Mobile

Referring Dentist

Referring Dentist

GDC No.

Practice address

Email

Tel

Mobile

Have you completed Level 1 CBCT training?

If not an additional fee of £150 will be charged for the CBCT to be reported externally by us

Yes

No

Referring Details

Reason for referral and clinical justification for CBCT scan?

What information do you want the dental CBCT examination to provide?

Patient to wear stent provided by dentist?

Yes No

OPG X-ray or Sectional 3D scan (CBCT)?

OPG CBCT

Justification for radiograph (this section must be completed)

Define the anatomical area that you would like the scan to cover

Mandible Maxilla Both Jaws

R

L

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

**Patients to
pay at visit**

*Patients are generally given the image data to take away with them on the day – both SIRONA DICOM

Export Wrap & Go and/or Raw DICOM data (to be imported into your own CT Viewing software – Simplant, iCat Vision, CS-3D etc.)

The CBCT image must be reported on by the referring dentist as per your service level agreement - we can arrange for an outside source to report on findings at an additional cost.

Important information: it is essential that you complete all sections of this form in full.

All incomplete forms will be returned to the referring dental practice, which may result in a delay in your patients' treatment.

The referring practice will be responsible for ensuring the clinical evaluation takes place and is properly recorded.

Date of referral:

Signature of referring dentist:



**The Sandford
306 Broadway
Bexleyheath, Kent
DA6 8AA**