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Sandwich
CT13 EB
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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?

Yes ☐ No ☐

Maxilla ☐

Mandible ☐

Full Arch (FOV 6 x 8 cm) ☐

Small Arch FOV (6 x 4 cm) ☐

Centre around which area?