HIGHCLIFFE DENTAL CARE

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CTCB Scan referral form

Date of request:

Referred by: Signature:

Address of practice:

Patients Title: Name: Surname:

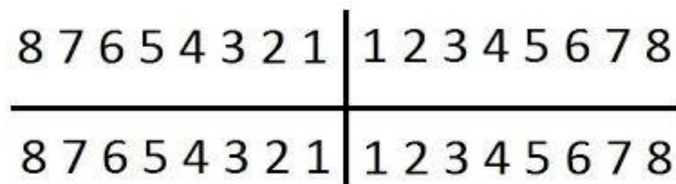
Date of Birth: / / Telephone:

Examination required:

☐Cone Beam CT ☐OPG ☐Patient will wear a stent

Region of interest:

☐Upper Jaw ☐Lower Jaw ☐TMJ ☐Small volume indicate on diagram



Justification for CBCT Scan:

Please tick as appropriate:

☐ I would like the study to be reported by a Consultant Radiologist

☐ I will make alternative reporting arrangements