Clinical Request Form for Dental CT Scan

Patient Details (Please use BLOCK capitals)

Patient's Name: ..... Date of Birth: .....

Tel No: Home: ..... Work: ..... Mobile: .....

Address: .....

..... Postcode: .....

E-Mail address: .....

Possibility of pregnancy: Yes / No

Examination Required (Please tick √)

CT MAXILLA ☐ **CT MANDIBLE** ☐ **BOTH** ☐

All images will be taken parallel to the occlusal plane unless you specify a different orientation here:

.....

.....

Clinical Indication (Please specify)

It is an IRMER requirement that all CT scans must be justified. Please give full clinical details of the site & anatomical features to be imaged.

.....

.....

.....

Patient to wear stent provided by dentist: Yes / No

Delivery Option (Please tick √)

☐ I – CAT VISION (FREE) ☐ DICOM CD

☐ SIMPLANT 1 SHOT ☐ SIMPLANT PLANNER

Billing Option (Please tick √)

☐ Invoice Patient ☐ Invoice Referrer

Referrer Details (* *Must be completed)*

Signature*: ..... Print Name*: .....

Contact Details: .....

Referrer E-mail: .....

Referrer Tel No: .....