Dental Imaging Referral Form

Referring Dentist Details

Clinicians Name:		**GDC Number:**	
Practice Name:			
Address:			
Postcode:			
Telephone:		Email:	

Patient Details

Patient's Name:		Date of Birth:	
Patient's Address:			
Postcode:			
Contact No.		Email:	

Examination Required

☐ OPG £35

☐ CBCT Scan £175 ☐ Mandible ☐ Maxilla ☐ Both Jaws

☐ Yes ☐ No

Is the patient coming with a Radiographic template?

☐ Full Arch FOV ☐ Small FOV

Area of Interest:

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

Purpose of scan e.g. Implant Planning _____

Reporting

We do not routinely report upon scans and radiographs. To comply with the IRMER 2017 regulations all radiographs and scans are required to be reviewed and reported into the clinical notes by the referring practitioner or by a radiologist. We strongly recommend that all CBCT scans are reported on to rule out the possibility of coincidental pathology. We offer a reporting service by a Consultant Radiologist at an additional cost.

☐ I will arrange my own reports

☐ I would like Langmans to arrange for a radiologist to provide a report and understand that the cost is £50 for a 5x5 volume scan, £75 for an 8x5 volume scan and £100 for an 8x8 volume scan.

PTO

Payment

☐ Invoice referring clinician

☐ Patient to pay on day

☐ I confirm patient has been informed of the charge

Signature _____ Date _____

Please post a completed copy to: Barbara Keyte, Practice Manager, Langmans Dental Health Centres, 28 Ely Street, Stratford Upon Avon, CV37 6LW. Alternatively a copy can be emailed to barbara@langmansdental.co.uk. We endevour to respond within 48 hours of receiving referrals.