



Glumangate Dental Practice

46 Glumangate • Chesterfield • S40 1TX

Tel: 01246 273089

contact@glumangatedental.co.uk

www.glumangatedental.co.uk

Cone Beam CT Scan / OPT Referral Form

Patient Details
Title:
First Name:
Last Name:
Address:
Postcode:
Date of Birth:
Home Telephone:
Mobile Telephone:

Referring Dentist Details
Name:
Practice Name:
Practice Address/Stamp:

Radiographs
<input type="checkbox"/> Please enclose relevant radiographs (if appropriate)

Medical History:
Drugs:
<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker

Required Scan: <input type="checkbox"/> Digital OPT £29 <input type="checkbox"/> Cone Beam CT Scan – Maxilla £95 <input type="checkbox"/> Cone Beam CT Scan – Mandible £95 <input type="checkbox"/> Cone Beam CT Scan – Both Jaws £125 <input type="checkbox"/> Cone Beam CT Scan – Sextant £75 Please indicate tooth at the centre of the required sextant;	Reporting: <input type="checkbox"/> Referring clinician will undertake reporting. <input type="checkbox"/> Consultant Radiologist Report; OPT £40 Sextant £40 Single Jaw £80 Both Jaws £100
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Clinical Justification:

Payment: <input type="checkbox"/> Patient <input type="checkbox"/> Invoice Practice
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Referring Clinician Signature:	Date:
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Please tick if you need more:	<input type="checkbox"/> Implant Referral Forms	<input type="checkbox"/> Cone Beam CT Scan Referral Forms
<input type="checkbox"/> Periodontal Referral Forms	<input type="checkbox"/> Periodontal Patient Information Leaflets	<input type="checkbox"/> Periodontal Care Pathway