



Glumangate Dental Practice

46 Glumangate • Chesterfield • S40 1TX

Tel: 01246 273089

contact@glumangatedental.co.uk

www.glumangatedental.co.uk

CBCT Scan / OPT Referral Form

You can also refer online: www.glumangatedental.co.uk/refer

Patient Details	Referring Dentist Details
Title:	Name:
First Name:	Practice Name:
Last Name:	Practice Address/Stamp:
Address:	Practice/Dentist Email Address:
Postcode:	
Date of Birth:	
Phone Number(s):	
Email Address:	
	Radiographs
	<input type="checkbox"/> Please enclose relevant radiographs (if appropriate)

Medical History:

Drugs:

<p>Required Scan:</p> <p><input type="checkbox"/> Digital OPT £32</p> <p><input type="checkbox"/> Cone Beam CT Scan – Maxilla £95</p> <p><input type="checkbox"/> Cone Beam CT Scan – Mandible £95</p> <p><input type="checkbox"/> Cone Beam CT Scan – Both Jaws £125</p> <p><input type="checkbox"/> Cone Beam CT Scan – Sextant £95</p> <p>Please indicate tooth at the centre of the required sextant;</p>	<p>Reporting:</p> <p><input type="checkbox"/> Referring clinician will undertake reporting.</p> <p><input type="checkbox"/> Consultant Radiologist Report;</p> <p>OPT £55</p> <p>Sextant £55</p> <p>Single Jaw £85</p> <p>Both Jaws £100</p>
<p>Clinical Justification:</p>	

Payment: Patient Invoice Practice

Referring Clinician Signature: _____ **Date:** _____

Please tick if you need more:

Oral Surgery / IV Sedation Referral Forms Endodontic Referral Forms 3D Intra-oral Scan Referral Forms

Periodontal Referral Forms Implant Referral Forms Cone Beam CT Scan / OPT Referral Forms