Cone Beam CT Scan / OPT Referral Form

Glumangate Dental Practice
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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
☐ Please enclose relevant radiographs (if appropriate)

Medical History:

Drugs:

☐ Smoker ☐ Non-Smoker

Required Scan:

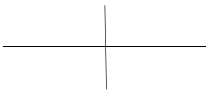
☐ Digital OPT £29

☐ Cone Beam CT Scan – Maxilla £95

☐ Cone Beam CT Scan – Mandible £95

☐ Cone Beam CT Scan – Both Jaws £125

☐ Cone Beam CT Scan – Sextant £85
Please indicate tooth at the centre of the required sextant;



Reporting:

☐ Referring clinician will undertake reporting.

☐ Consultant Radiologist Report;

OPT	£50
Sextant	£50
Single Jaw	£80
Both Jaws	£100

Clinical Justification:

Payment: ☐ Patient ☐ Invoice Practice

Referring Clinician Signature:	Date:

Please tick if you need more:

☐ Implant Referral Forms ☐ Cone Beam CT Scan Referral Forms

☐ Periodontal Referral Forms ☐ Periodontal Patient Information Leaflets ☐ Periodontal Care Pathway