Acton Vale
DENTAL CENTRE

CBCT Referral Form

Please complete and return to info@actonvaledentists.com or to the practice address below:

179-181 The Vale
Acton
W3 7RW
Tel: 020 8749 3267

Referring Dentist Details	
Name	
GDC Number	
Practice Address	
Postcode	
Telephone Number	
Email Address	

Patient Details	
Name	
Date of Birth	
Address	
Postcode	
Telephone Number	
Email Address	

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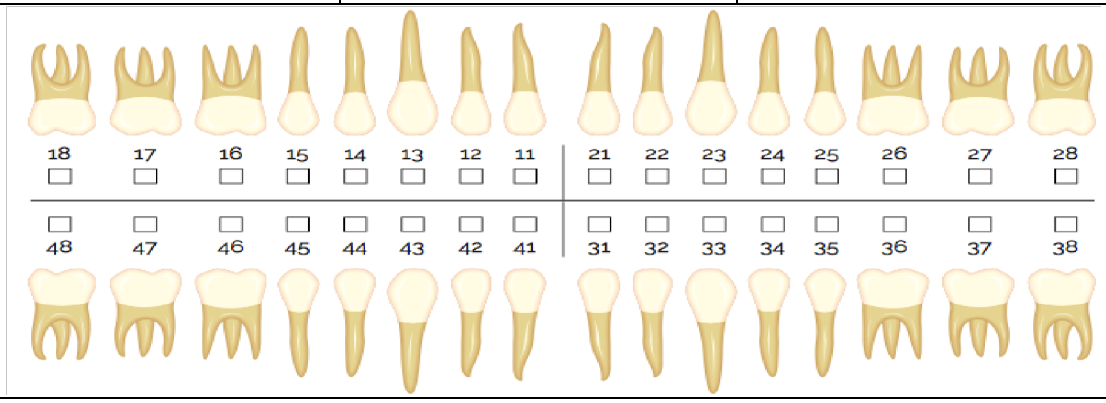
Justification		
Reason for CBCT	Pre-implant assessment	
	Wisdom tooth assessment	
	Other (please specify)	
What information do you want the CBCT examination to provide?		
Describe specific anatomic structures requiring visualisation (i.e. maxillary sinus, inferior alveolar canal etc.)		
Please indicate if you would like scan taken in high/low/standard definition		
Any additional information		

Area of Interest (please tick)		
Sectional (5x5cm^3) 4 teeth max ☐	Maxilla (8x8cm^3) ☐	Mandible (8x8cm^3) ☐



Appliances
Has the patient been given any appliances to wear for the CBCT (e.g. scan guide)? If so, please specify below.

Cost and Payment (please tick) Single Arch **£150** ; Dual Arch **£250**	
Patient to Pay: ☐	Account to settled by referring practice: ☐

Reporting of Scan (please tick)
I confirm I am a qualified IRMER referrer (minimum CBCT Level 1 Core Training) and I am aware that Acton Vale Dental Practice will not be providing a reporting service of the CBCT request* ☐

Service Level Agreement for the Referral of Patients to Acton Vale Dental Practice for Dental CBCT Examinations	
This agreement is between:	
Acton Vale Dental Centre 179-181 The Vale Acton W3 7RW 0208 749 3267 info@actonvaledentists.com	Referring Clinician: Address: Postcode: Tel: Email:
GDC number	

Justification (please tick)	
☐	I agree to use the referral criteria as per the European Guidelines: Radiation Protection No.172 and provide adequate clinical information in order for each examination to be justified
Reporting (please tick one of the following)	
☐	I will make my own arrangement for the reporting of the Cone Beam CT scan. (This will be done by someone adequately trained as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT)
☐	I will report my Cone Beam CT scans acquired at Acton Vale Dental Practice. (I confirm that I am adequately trained to interpret cone beam CT scans as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT.

Acton Vale Dental Practice		**Referring Clinician**	
Signature		Signature	
Date		Date	

**Dear Referrer: Please be aware that Acton Vale Dental Practice is not currently offering a CBCT reporting service. It is the responsibility of the referring practitioner to organise a reporting service with an accredited*

professional. By completing this form you confirm you have obtained consent from the patient to share their personal data via non-encrypted email, in line with GDPR data security.