BOND DENTAL
CLINIC

CBCT and OPG Referral Form

Confidential and Protected Document

Referring Dentist Details

Referring Dentist Name: _____ Date of Referral: _____

Practice Name: _____ Telephone: _____

Practice Address: _____

Practice Email Address: _____

Patient Details

Title: _____ First Name: _____ Last Name: _____

Middle Name(s): _____ Date of Birth: _____

Address: _____ Postcode: _____

Email Address: _____ Home/Mobile Number: _____

Purpose of Referral: *(fees collected directly from the patient)*

☐ **OPG** £60 ☐ **CBCT** without report £180 ☐ **CBCT** with report £280

Referral Requirements:

The referring dentist is responsible for supplying us sufficient information to justify an appropriate exposure. We request all parts of this form to be completed in advance to avoid any delay arranging the patients appointment.

Reason and Justification: _____

_____

Relevant Medical history: _____

_____

2D field of view required:

Full: ☐ Full OPG inc condyles ☐ Full OPG excluding condyles ☐ Condyles only ☐ Bitewings (if patient unable to tolerate I/O films)

Sectional: ☐ URQ ☐ ULQ ☐ Full Maxilla ☐ LRQ ☐ LLQ ☐ Full Mandible

Exposure: ☐ Regular *(high quality image)* ☐ Quick *(reduced exposure, good quality image)*

Patient Size: ☐ Size 1 (child) ☐ Size 2 (small adult) ☐ Size 3 (average adult) *standard exposure* ☐ Size 4 (large adult)

3D field of view: For CBCT referrals, if an intra-oral radiograph of the area is available please attach it for justification purposes.

8x8cm
- ☐ Full upper
- ☐ Full lower
- ☐ Full upper and lower
- ☐ URQ
- ☐ ULQ
- ☐ LRQ
- ☐ LLQ

5x5cm (sectional)
- ☐ UR8-6
- ☐ UR6-4
- ☐ Upper 3-3
- ☐ UL4-6
- ☐ UL6-8
- ☐ LR8-6
- ☐ LR6-4
- ☐ Lower 3-3
- ☐ LL4-6
- ☐ LL6-8

11x10cm ☐ Full upper and lower including complete maxillary sinus view

Exposure: Standard image resolution will be used unless you specifically request high or low resolution.

☐ High Definition (HD) ☐ Low resolution

Radiographic stent to be worn: ☐ YES ☐ NO

Reporting: ☐ I would like a report by the Consultant Radiologist Rebecca Davies

☐ I will take responsibility and undertake to report on radiographs / scan as required by IR(ME)R 2000/2006

Declaration: By completing below, you declare that you:

☐ Agree and understand to the processing of your personal data as the referring clinician

☐ Agree you have made the patient aware of this referral and the provision of their data for this purpose

☐ Have received Level 1 CBCT training to request this referral ☐ Have received Level 2 CBCT training to report on this scan

- Are registered and appropriately trained to request radiographic investigation.
- Will consent your patient in advance of the investigation and have informed them of the accociated involved.

Dentist Signature:_____ **GDC No:** _____

Unless otherwise specified the image data will be supplied in DICOM format. The Sidexis viewing software (compatible with Windows) will be included in the file. Files will be password protected and sent to the e-mail provided via WeTransfer.

This confidential form provides us with the information we require to receive a patient referral. The information contained within this form should be true and accurate to the best of your knowledge and with the patients consent. By submitting this form, we will securely collect yours and your patients details. We will then store and process this information in accordance with our Privacy Policy, a copy of which can be found on our website.

Thank you for your referral

Please email referrals to **info@bonddentalclinic.co.uk, or post to 37 Castle Street, Salisbury, SP1 1TT**
For general enquiries please call 01722 417007