CIRENCESTER DENTAL PRACTICE

REFERRAL FORM

Please delete as appropriate: **CB CT Referral** **OR** **Implant Referral**

REFERRING DENTIST DETAILS

Full Name: ………………………………………………….. Date Referred: …………………..……..

Address: ……………………………………………………………………………………..……...

…………………………………………………………………………………………………..……...

…………………………………………………………………… Postcode: …………………………..…..

Telephone: …………………………………… E-mail: ………………...……………………...…………..

PATIENT DETAILS

Patient's Name: ………………………………………………….. Date of Birth: …………..……..……..

Patient's Address: ………………………………………...……………….………………………...

…………………………………………………………………………………………………..……...

…………………………………………………………………… Postcode: ………………...………..

Home Tel: …………………………………… Work Tel: ………………...……………………………..

Mobile Tel: ………………………...……… E-mail: ………………...……………………...………..

☐ **CBCT** ☐ **Digital Panoramic**

Region of interest and purpose of examination:

……………………………………………………………………………

……………………………………………………………………………

……………………………………………………………………………

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☐ Maxilla ☐ Mandible ☐ Sinus

FIELD OF VIEW:

☐ 12 cm x 8.5 cm ☐ 8.5 cm x 8.5 cm

☐ 8.5 cm x 5 cm ☐ 5 cm x 5cm

Patient to wear Radiographic Marker?

☐ Yes ☐ No

FORMAT DATA DELIVERY OPTIONS FOR CT SCAN:

☐ Simplant Planner ☐ Dicom ☐ Prints

☐ Duplicate CD ☐ Email ☐ CD

☐ Other: ……………...…………………...….

IMPLANTS – REASON FOR REFERRAL:

☐ Implant Assessment Advice

☐ Implant Surgical Placement Only

☐ Implant Surgical Placement & Restoration

☐ Implant Problems & Diagnosis

☐ Augmentation & Surgical Placement

Cirencester Dental Practice does not routinely report upon scans and radiographs. To comply with the IRMER 2000 regulations all radiographs and scans are required to be reviewed and reported into the clinical notes by the referring practitioner or by a radiologist. Cirencester Dental Practice strongly recommends that all CT and other radiographic examinations should be reported upon to rule out the possibility of coincidental pathology. Cirencester Dental Practice offers a reporting service by a Consultant Radiologist (**PLEASE TICK**):

☐ I would like this patient's radiographic examination to be reported upon by your Consultant Radiologist.

☐ I will make my own reporting arrangements.

PAYMENT: ☐ **Account to Referrer** ☐ **Patient to pay**

Once completed, please send by FAX to 01285 640258 or
Scan and Email re. Implant Referrals to: referrals@cirencesterdentalpractice.com
Scan and Email re. CB CT Referrals to: cbctscans@cirencesterdentalpractice.com
PLUS Please put the original signed Form in the post to Cirencester Dental Practice

Cirencester Dental Practice
The Old Post Office, 12 Castle Street, Cirencester, GL7 1QA Tel: 01285 640248 Fax: 01285 640258