

Dental CT Scan Request Form

Patient Details:

Title: Initials: PIN:

First Name: Surname:

D.O.B.: Preferred Contact Method:

Address:

Home Tel: Work Tel:

Mobile Tel: Email:

Notes:

Referring Dentist Details:

Dentist Name: Contact Nos:

Address: Postcode:

Reason for scan and justification:

I undertake to report on the entirety of CBCT scan volume and comply with guidelines detailed within SEDENTEXCT project.

OR

I will arrange a radiologist report on the volume and I will comply with guidelines detailed within the SEDENTEXCT project.

Dentist Signature:

GDC Number:

CT Scan Requirements:

Parallel to occlusal plane

Parallel to the lower border mandible

Parallel to hard palate maxilla

Small FOV

Very high quality; 85µm

Medium quality; 133µm

Low quality; 200µm

Very low quality; 210µm

Large FOV

Very high quality; 200µm

Medium quality; 300µm

Very low quality; 330µm

Radio-opaque markers to be worn? Yes/No

Centre Around



CT Scan Charges:

Single Jaw Scan on CD £104.00

Double Jaw Scan on CD £188.00

CBCT data will be sent on CD as DICOM files