GUILDHALL DENTAL
BURY SAINT EDMUNDS

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

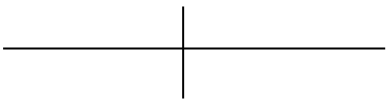
Very high quality; 85µm ☐
Medium quality; 133µm ☐
Low quality; 200µm ☐
Very low quality; 210µm ☐

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	£110.00
Double Jaw Scan on CD	£199.00

CBCT data will be sent on CD as DICOM files

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