RHIWBINA DENTAL

CBCT (3D scan)
Sirona Galileos

Referring IRMER practitioner name: Practice address: Practice contact number: Email address:

Patient name:	
Patient address:	
Preferred contact number:	
Email address:	
Date of birth:	
I, the patient agree to be referred to Smile concepts for digital imaging as requested by my dentist and I have had the reasons for my referral explained to me. Signed: _____	

This section MUST be completed IN FULL by the referring dentist only

PLEASE TICK OPG ☐ or Sectional 3D scan ☐

Justification for radiograph (this section must be completed)

Define the anatomical area that you would like the scan to cover, see example below. *
i.e. UL4 pre-assessment for possible implant treatment. 8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

The 3D scan volume is a cylinder with **50mm diameter and **37mm** height*
Please circle the area(s) to be scanned

Please tick:	Patient to pay at visit	☐	Invoice referring practice	☐
Please tick:	Patient to take image away with them	☐	Send image to referring practice	☐
Signature of referring dentist:				

The CBCT image will be reported on by the referring dentist.

Important information: it is essential that you complete all sections of this form in full.

All incomplete forms will be returned to the referring dental practice, which may result in a delay in your patients' treatment.

As per your service level agreement dental CBCT images will be reported on by the referring practice. The referring practice will be responsible for ensuring the clinical evaluation takes place and is properly recorded.

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