CBCT SCAN REFERRAL FORM

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NORTH LIGHT DENTAL

Referring Practitioner

Name

Practice

Address

Tel

Email

Patient Details

Name

Date of Birth

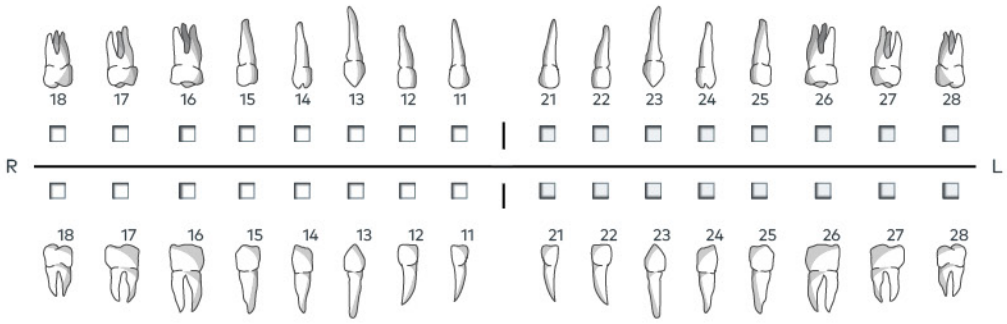
Address

Tel

Email

Area of interest

- ☐ Mandible
- ☐ Maxilla
- ☐ Both jaws
- ☐ **Localised 5x5cm scan**: 4-6 teeth dependent on the area of the jaw. *Please mark area below.*



- ☐ Patient to wear radiographic stent during scan

Justification for scan

- ☐ Implants
- ☐ Impacted teeth
- ☐ Endodontics
- ☐ Sinus exam
- ☐ Orthodontics
- ☐ Other

Clinical indications *(required in all cases)*

Format required

- ☐ Dropbox
- ☐ We Transfer
- ☐ Other

Email address scan to be sent to:

Extras

(please enquire for prices)

- ☐ Simplant conversion
- ☐ Radiologist report

Referrer's signature **Date**

Thank you for your valued referral. www.northlightdental.co.uk