Alchemy
DENTAL PRACTICE LTD transforming smiles

CBCT SCAN REFERRAL FORM

PATIENT DETAILS			
Patients Title and Name	Age of patient in years	Sex	Date of Birth (DD/MM/YY)
Patient Address			
Mobile Telephone Number	Home Telephone Number	E-mail address	

REFERRAL INFORMATION		
Referring Dentist Name	Referring Dental Practice	Date of decision to refer
GDC Number of referring dentist		

SURGICAL STENT

I can confirm patient will be attending appointment with a surgical stent Yes ☐ No ☐

Additional Information: .....

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TREATMENT REQUESTED

Scan Justification: .....

5x5 FOV ☐

5x8 FOV ☐

8x9 FOV ☐

Maxilla ☐

Mandible ☐

Brief description of treatment required:

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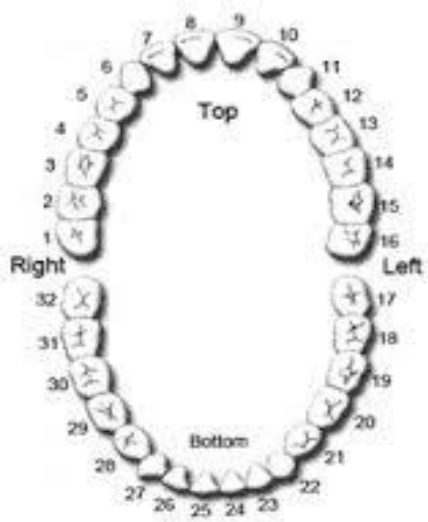

PATIENT CONSENT TO REFERRAL	
Has the patient understood and consented to the referral? Yes ☐ No ☐	Is the patient aware of the £99.00 fee? Yes ☐ No ☐
CONFIRMATION AND SIGNATURE OF REFERRING DENTAL PRACTITIONER	
Print Full Name..... Signature.....	Date.....

Please send all referrals to the following address:

Lauren Platt

Referral Centre

Alchemy Dental Practice
203 Edleston Road
Crewe
Cheshire
CW2 7HT

Telephone: 07848830091

Alternatively referral forms can be emailed using the email address: lxp@alchemydental.co.uk