**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 |  |
| **TREATMENT REQUESTED** |
|  Scan Justification: ..................................................................................................5x5 FOV Maxilla 5x8 FOV Mandible 8x9 FOV ToothBrief description of treatment required:......................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................................... |
| **PATIENT CONSENT TO REFERRAL** |
| Has the patient understood and consented to the referral? Yes No |  Is the patient aware of the £160 fee?Yes No  |
| **CONFIRMATION AND SIGNATURE OF REFERRING DENTAL PRACTITIONER** |
| Print Full Name..............................................................................................Signature...................................................................................................... | Date.......................................... |

Please send all referrals to the following address:

Referral Centre
Alchemy Dental Practice
203 Edleston Road
Crewe
Cheshire
CW2 7HT

Telephone: 0127021171

Alternatively, referral forms can be emailed using the email address: tco@alchemydental.co.uk with ‘External Referrer’ in the subject line.

Appointments will be allocated dependent upon need and availability