

REFERRER DETAILS AND DELIVERY ADDRESS

Name of Referrer:

Practice name:

Address:

Telephone:

Email:

PATIENT DETAILS

Appointment Date : / / Time:

Name & Surname:

Date of Birth: / / Telephone:

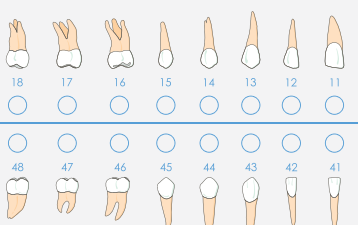
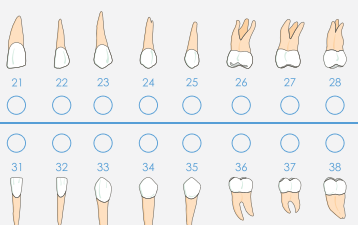
First Line of Address (required for patient identification under IRMER):

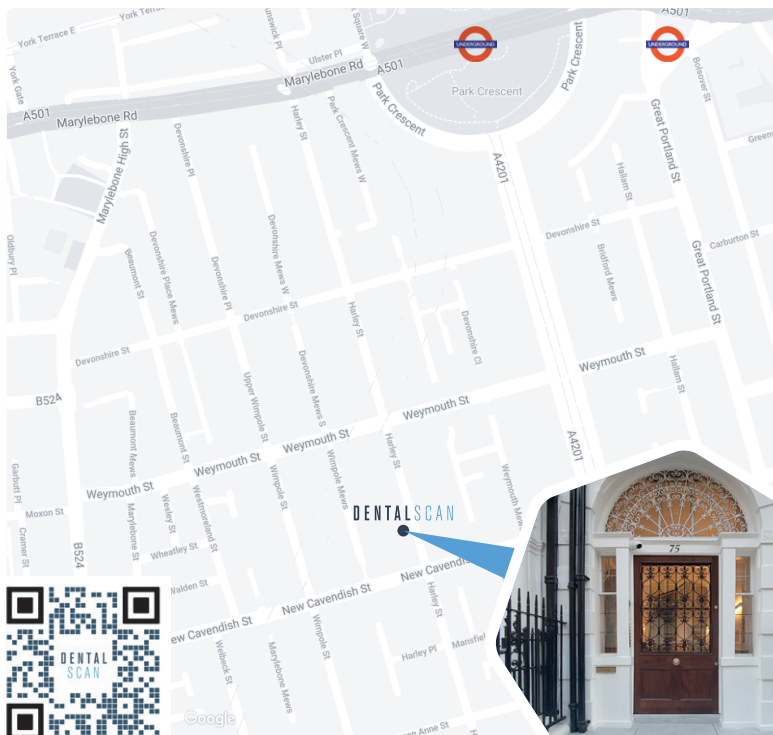
Email:

Radiographic template with patient? Denture Marked Separate Template

AREA OF INTEREST CBCT ONLY

Sectional Quadrant Mandible Maxilla Both Jaws

R  L 



CBCT FORMAT

- i-CAT Vision
- Cloud Viewer (PACS)
- DICOM Files
- SimPlant Planner
- SimPlant View
- SimPlant OneShot
- NobelClinician
- InVivo6 Viewer

JUSTIFICATION FOR X-RAY

- Implants
- Bone Grafting
- Impacted Teeth
- Endodontics
- Perio
- Airway Assessment
- Sinus Exam
- TMJ
- Oral Pathology
- Ortho

2D IMAGING

- Panoramic (OPG/OPT)
- Lateral Ceph (CEPH)
- PA Ceph (CEPH)
- Bitewings

CBCT OUTPUT

- Secure Link
- CD
- PDF

2D OUTPUT

- Secure Link (JPG)
- DICOM Files
- Cloud Viewer (PACS)
- Photopaper

EXTRAS

- Radiology Report (UK)
- Express Processing
- Ceph Tracing Report
- Extra copy
- AI Segmentation

ITERO - INTRA ORAL

- Invisalign Upload
- .STL Secure Link

PAYMENT

- Patient
- Practice

CLINICAL INDICATIONS (mandatory)

SIGNATURE

DATE

/ /

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Our radiographers will always base the scanning protocol (field of view, resolution and exposure settings) on the justification for referral, age and anatomy of the patient.