DENTALSCAN REFERRAL FORM

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:

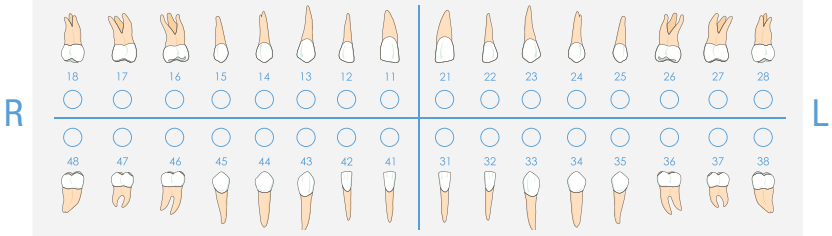
Radiographic template with patient? ☐ Denture Marked ☐ Separate Template

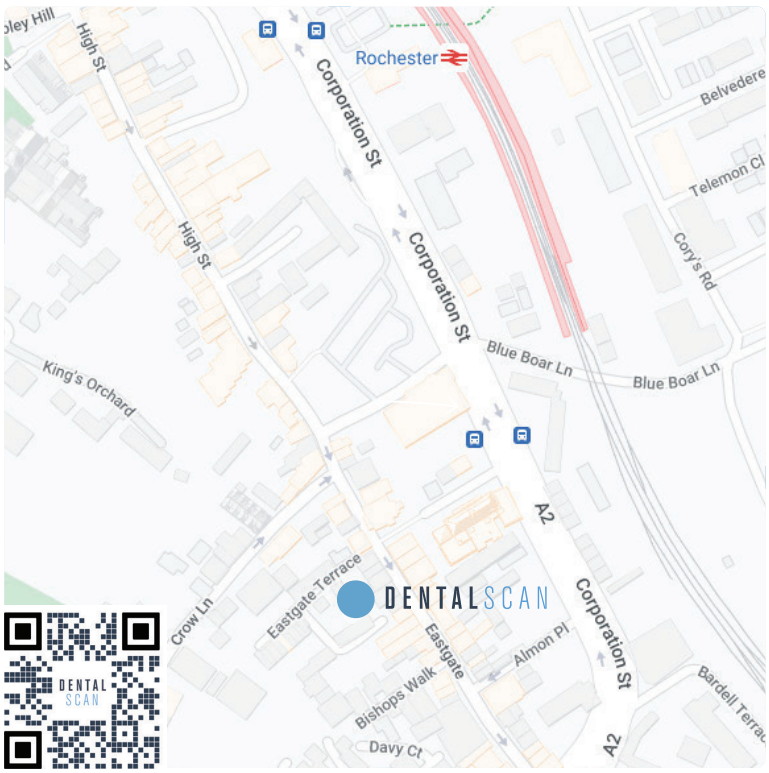
AREA OF INTEREST CBCT ONLY

☐ Sectional (5x5cm) ☐ Quadrant (8x6cm) ☐ Mandible (11x6cm)

☐ Maxilla (9x6cm) ☐ Both Jaws (9x10cm)

☐ Both Jaws + Full Sinuses (9x13cm) ☐ Maxilla + Full Sinuses (9x8cm)





CBCT FORMAT

- ☐ i-CAT Vision
- ☐ Xelis Dental Viewer
- ☐ DICOM Files
- ☐ SimPlant Planner
- ☐ SimPlant OneShot
- ☐ NobelClinician
- ☐ InVivo6 Viewer
- ☐ Cloud Viewer (PACS)
- ☐ DTX

JUSTIFICATION FOR X-RAY

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

CBCT OUTPUT

- ☐ Secure Link
- ☐ CD
- ☐ PDF
- ☐ Photopaper

2D IMAGING

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

RADIOLOGY REPORT

- ☐ Rule out Pathology
- ☐ Implant Planning
- ☐ Highlight ID Canal
- ☐ Implant Measurements
- ☐ 24-Hour Report

2D OUTPUT

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

EXTRAS

- ☐ Express Processing (up to 20 min)
- ☐ Ceph Tracing Report
- ☐ Extra copy
- ☐ Patient copy by email

PAYMENT

- ☐ Practice
- ☐ Patient

CLINICAL INDICATIONS (mandatory)

SIGNATURE

DATE

/ /

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