



Date of Referral

## PATIENT DETAILS

Name

Date of Birth

Address

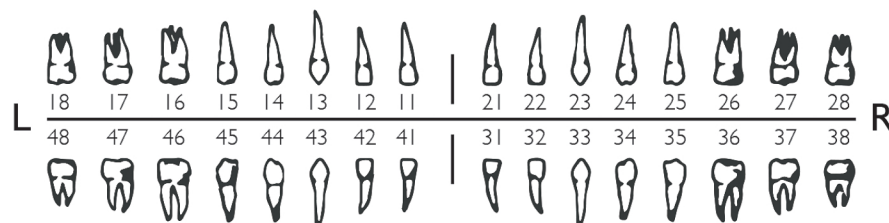
Postcode

Contact Telephone

Email

## REFERRAL DETAILS

Please circle the area of interest



Volume of Scan (please tick)

- 2D DPT - £55
- 3D 8 × 8 - £250  
(Upper & Lower Arch)
- 3D 5 × 8 - £125  
(Full Arch)

The clinical context for requesting the scan, including justification:

Are there relevant radiographs of the area?

- Yes (please enclose)       No

## REPORTING OF SCANS

Please tick which of the following applies to you:

- Implants
- Endodontics
- Extraction
- Oral Pathology
- Bone graft
- Sinus exam
- Orthodontics
- Impacted teeth

- I am the IRMER referrer only. I wish NDS radiologist to provide me with a report on my patient's scan. I have advised my patient that the fee will be £250.
- I am the IRMER referrer / operator. I am adequately trained to report on my patient's scan. I have advised my patient that the fee will be £130.

## REFERRER DETAILS

Name

Practice

Address

Postcode

Contact Telephone

Email

Signature

GDC No.