WEYBRIDGE ORTHODONTICS
WE CREATE SMILES

Dental CT Scan Request Form

Patient Details:

Title: .....First Name: ..... Surname: .....

D.O.B.: ..... Preferred Contact Method: .....

Address: .....

Postcode: ..... Email: .....

Home Tel: ..... Work Tel: ..... Mobile: .....

Notes: .....

Referring Dentist Details:

Dentist Name: ..... Practice Tel.: .....

Practice Name: .....

Practice Address: .....

Postcode: ..... Dentist Email: .....

Reason for scan and justification: .....

Dentist Signature: .....GDC Number: .....

CT Scan Requirements:

All scans will be parallel to the occlusal plane unless otherwise specified. Scans are on CD.

Maxilla: ☐ Mandible: ☐

Small FOV (6 x 4cm):

Centre on:

87654321/12345678
87654321/12345678

CT Scan Charges:

Single Quadrant Jaw Scan	£125.00
Arch	£175.00
Full Scan	£225.00

I undertake to report on the scan as required by IR(ME)R 2000/2008.

Dentist Signature: .....

Payment will be collected from patient on the day of the Scan.

Please clearly specify the diagnostic aims of this scan:.....

Complete and return to the address below:

BDA goodpractice

35 Monument Hill
Weybridge
Surrey KT13 8RN

f. 01932 858864
e. info@weybridgeortho.com
w. www.weybridgeortho.com