

**CBCT Scan Request Form**

**Patient details:** Title: First name: Last name:

Address:

Post code:

Telephone: (H) (Mobile)

Email: Date of Birth:

**Referring Dentist Details:**

Dentist Name: Practice:

Practice Address:

Postcode: Practice Telephone:

Email:

Brief patient history:

Reason for scan:

**CBCT scan requirements:**

All scans will be parallel to the occlusal plane unless otherwise specified. Radio-opaque marker to be worn? **Yes** **No**

Field of view: Full Upper( 8x10) Full Lower(8x10)

 Full upper and lower( 10x10)

 Sectional ( 6x7) + (6x6) - Please mark area(s) on diagram

**Cbct scan charges c.d only- £100**

Dentist signature GDC Number

STANDARD IMAGE RESOLUTION WILL BE SUPPLIED UNLESS YOU SPECIFCALLY REQUEST HIGH RESOLUTION OR ENDO

ASSISTANCE WITH CASE PLANNING- PROCE ON APPLICATION

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