



CBCT / OPG / intraoral scan Referral Form

Please complete all of the fields as appropriate.

COTTINGHAM HOUSE
190-192 KING STREET
COTTINGHAM
EAST YORKSHIRE HU16 5QJ

TEL: 01482 848655
FAX: 01482 841897

Date / /

Dentist details

Referring dentist

GDC number

Address

Postcode

Telephone

Email

Patient details

Title (Mr/Mrs etc) Gender M F Name

DoB / / Contact address

Postcode

Contact telephone: Home

Work

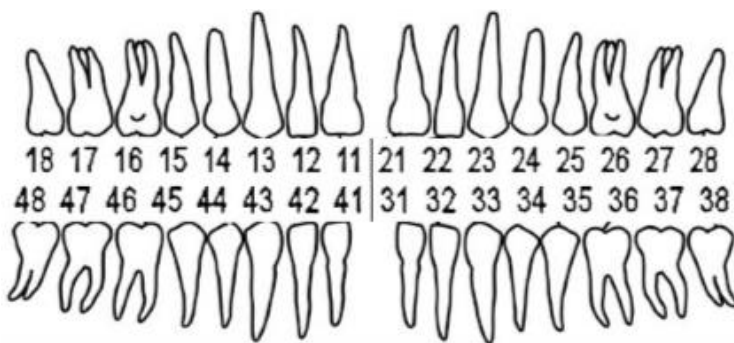
Mobile

Email

Please circle the area of interest

Dentist's reason for CBCT/OPG

referral (clinical context for requesting scan,
including justification)



Reporting of scans

Please tick this box to confirm the following details:

I am the IRMER CBCT trained referrer. I am adequately trained to request a CBCT/OPG and I will report on my patient's scan. I have informed my patient of the cost of the scan (see details over the page).

Fee to be paid by:

Patient

Dentist/practice

Signature

Scan volume for CBCT	Tick	Fees
Small volume 5 x 5cm	<input type="checkbox"/>	£100.00
Small volume high resolution 5 x 5cm	<input type="checkbox"/>	£100.00
Medium volume 8 x 5cm Upper or lower jaw	<input type="checkbox"/>	£150.00
Large volume 8 x 9cm Full mouth	<input type="checkbox"/>	£200.00
Scan of object eg stent, model, impression	<input type="checkbox"/>	£25.00
OPG	<input type="checkbox"/>	£65.00
Intraoral scan		
Upper arch	<input type="checkbox"/>	£25.00
Lower arch	<input type="checkbox"/>	£25.00

Images are sent out via email so please make sure we have got your correct email address.

PAYMENT

We will take payment from the patient at the time of their appointment. However if the patient states that the dentist is to cover the cost without our prior knowledge, we will contact the practice for confirmation before the scan is taken.

Special instructions

Please email (referral@cottinghamdp.co.uk) or post this form back to Cottingham Dental Practice. Thank you.