



GATEWAY DENTAL

CBCT / OPG REFERRAL FORM

REFERRING DENTIST DETAILS

Dentist Name : _____
Practice Address : _____
Post Code : _____
Tel. Number : _____ Email : _____

PATIENT DETAILS

Patient Name : _____ DOB : _____
Patient Address : _____
Post Code : _____
Tel. Number : _____ Email : _____

REFERRAL DETAILS

Is the patient pregnant? : Yes No
Patient to wear Radiographic Stent? : Yes No
OPG (£60) :
CT SCAN (£160) : Mandible Maxilla Both Single Tooth ... & Number _____

Reason/Justification for OPG or CT scan (IRMER requirement):

I would like this patient's radiographic examination to be reported upon by your Consultant Radiologist for £150 Purpose of Examination and Interest:

Gateway Dental Practice does not routinely report upon scans and radiographs. To comply with the IRMER 2000 regulations all radiographs and scans are required to be reviewed and reported into the clinical notes by the referring practitioner or by a radiologist. Gateway Dental Practice strongly recommends that all CT and other radiographic examinations should be reported upon to rule out the possibility of coincidental pathology. Gateway Dental Practice offers a reporting service by a Consultant Radiologist at a cost of £150. I confirm that I am appropriately trained and competent to prescribe CBCT examinations in accordance with the GDC Scope of Practice, FGDP/SDCEP guidance and IR(ME)R 2017, and that the information provided is accurate and I meet the required professional training standards to prescribe CBCT examinations.

Referring Dentist Signature: _____ Date: _____

Gateway Dental IRMER Practitioner Approval Signature: _____ Date: _____