AINSTY DENTAL
& IMPLANT CLINIC

177 Boroughbridge rd, York, YO26 6AR   Telephone 01904 786196

CBCT Imaging Referral Form

Patient Details

Name: Date of birth:
Address:

Patient contact telephone numbers: H: M:

Referrer details
Name:
Address:

Referrer contact telephone number:
Email:
Signature: Date:

Justification for scan:

Define the anatomical area that the scan should cover:
Sectional (5cm x 5cm, recommended for the majority of applications): □

18 17 16 15 14 13 12 11 | 21 22 23 24 25 26 27 28
48 47 46 45 44 43 42 41 | 31 32 33 34 35 36 37 38

Full maxilla □
Full mandible □
Full maxilla and mandible □

Please tell us your preferences (please tick):
Patient to pay at visit □ Invoice referring practice □
CBCT Scan charge: Sectional £100, full arch or both arches £150

As in the Service Level Agreement dental CBCT images will be reported on by the referring practice. The referring practice will be responsible for ensuring the clinical evaluation takes place and is properly recorded.

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On completion, retain this form and return a copy to Ainsty Dental Practice: **mail@ainstydental.co.uk** **A copy of the image will be sent to the email address provided by the referrer.**