30 BEAUMONT STREET DENTAL CLINIC
30 Beaumont Street Oxford OX1 2NY

Please email form to: reception@30beaumontstreet.co.uk

CBCT SCAN REFERRAL FORM

PATIENT DETAILS

Title: Mr | Mrs | Ms | Miss | Master | Other:

First Name:

Surname:

DOB:

Tel (Home):

Tel (Mobile):

Email:

Address:

Referring Practioner:

GDC:

Practice Name:

Address:

Telephone:

Email:

I have obtained consent from the patient to share their personal data via non-encrypted email, in line with GDPR data security.

Signature: Date:

TO BE COMPLETED BY REFERRING PRACTITIONER

☐ Maxilla ☐ Mandible ☐ Both Jaws

	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	
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	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	

Is the patient coming with a radiographic stent? Y / N

Is the patient possibly pregnant? Y / N

☐ Implant Treatment Planning

☐ Bone Graft

☐ Impacted Teeth Assessment

☐ Endodontic Assessment

☐ TMJ

☐ Oral Pathology

☐ Orthodontics

Cost £170

CBCT RETURN:

☐ Given to Patient ☐ CD Posted (+ postage)

PAYMENT:

☐ Referrer ☐ Patient