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

CBCT SCAN REFERRAL FORM 2025

PATIENT DETAILS

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

First Name:

Surname:

DOB:

Telephone(Home):

Telephone(Mobile):

Email:

Address:

Referring Practitioner:

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:

TOBECOMPLETEDBYREFERRINGPRACTITIONER

☐ Maxilla ☐ Mandible ☐ Both Jaws

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

Reporting of CBCT Required £90 Y / N

CBCT RETURN:

Given to Patient ☐ CD Posted (+postage) ☐

☐ Implant Treatment Planning

☐ BoneGraft

☐ Impacted Teeth Assessment

☐ Endodontic Assessment

☐ TMJ

☐ OralPathology

☐ Orthodontics

Cost £193

PAYMENT:

☐ Referrer ☐ Patient

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