Venus
Dental Care
Implant Centre

CBCT scan Refferal Form

Patients details:

Title: ____________ First name: ______________________ Last neme: ____________________.

DOB: ________/________/________________________________.

Adress: ____.

______________________________________ Postcode: ____________________.

Tel: ______________________.

Email: ____.

Referring Dentist details:

Dentist name ______________________________ Practice: ____________________.

Practice address: ____.

Post code: ______________________________ Practice Tel: ____________________.

Email: ____.

Reason for referral with area of interest indication:

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Scans are reported by certified radiological analysts and are mandatory for all referrals. Purpose is pathology detection and indicated analysis requested by the referring clinician.

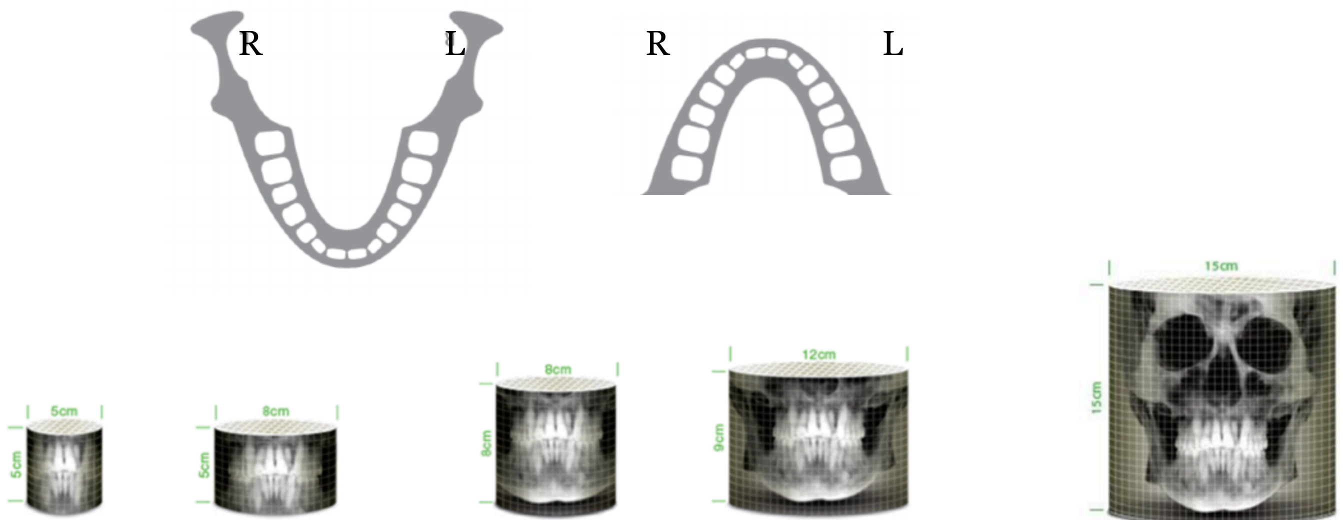
All scans with report included £230

Field of view:

( ) Full upper
( ) Full lower
( ) Left side only
( ) Right side only

( ) Full upper and lower (80x80 mm)
( ) Full upper and lower with TMJs (90x120 mm)
( ) Only TMJs both sides / left only / right only
( ) Full upper and lower arch, TMJs and airway volume analysis (150x150 mm)

( ) Sectional (50x50 mm) Please indicate the area on the diagram below:



Dentist signature ___________________________.

GDC nb: _______________________________.

Date __________________________________.

8 Symons Passage, TQ9 5YS, Totnes 01803 866 822