

CBCT SCAN REFFERAL FORM

Patients details:

Title: Mr First name: Andy Last neme: Harman

DOB: 23 / 03 / 1963

Adress: Trefagus, Truscott, Coxpark, Gunnis lake

Postcode: PLAT 9BB

Tel: 07710000215

Email: nic@nicharman.co.uk

Referring Dentist details:

Dentist name Dr Karina Patel Practice: London Sleep Centre

Practice address: 137 Harley Street, London

Post code: W1G 6BF Practice Tel: 0207 725 0523

Email: info@londonsleepcentre.com

Reason for referral with area of interest indication:

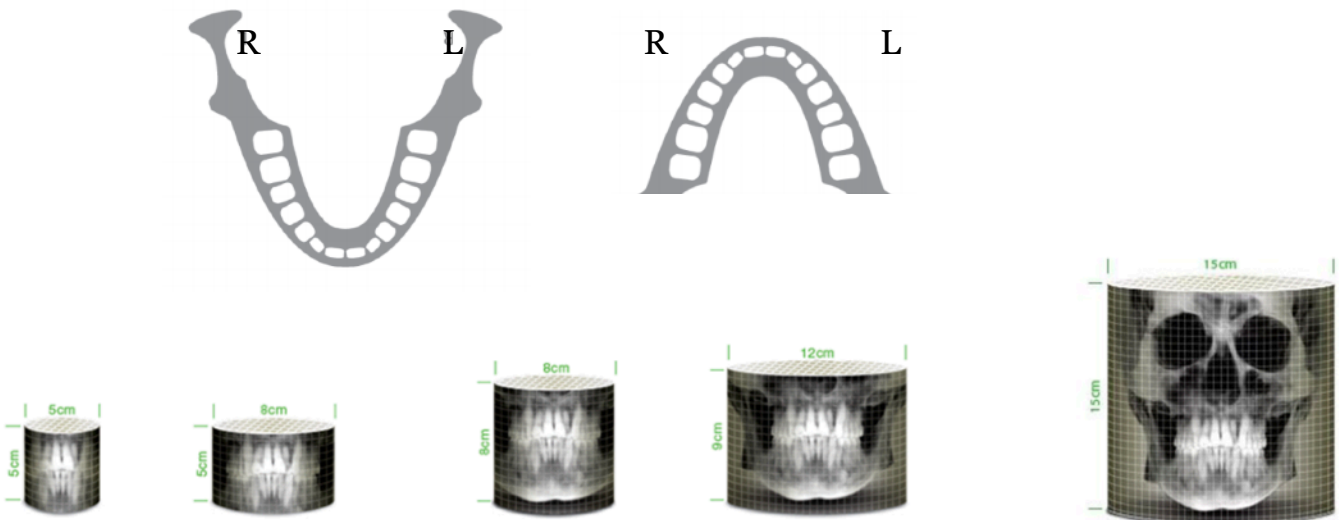
Airway study, TMJ, sinus, Nasal cavity, Oropharynx with volumetric analysis of the
Narrowest portion of the airway please.

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



Dentist signature 

GDC nb: 177919

Date 25/05/2021