Castle Park Dental Care
Here's to making a difference

CBCT Referral Form

REFERRING DENTIST DETAILS & DELIVERY ADDRESS

Name of referring clinician:

Address of referring clinician:

Practice name:

Telephone:

Practice email:

PATIENT DETAILS

Appointment Date: / / Time:

Patients Name:

Address:

Date of Birth: / /

Phone: Mobile:

Email:

CBCT OUTPUT
AREA OF INTEREST CBCT ONLY

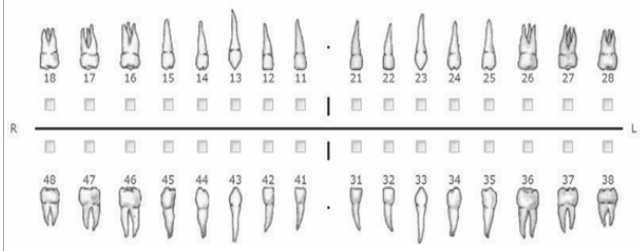
2D IMAGING **2D OUTPUT**

☐ DVD ☐ Dropbox ☐ Planmeca Cloud

2D IMAGING	2D OUTPUT
☐ Digital Panoramic (OPG)	☐ DVD ☐ Dropbox ☐ Planmeca Cloud

PAYMENT ☐ Dentist ☐ Patient

☐ Mandible ☐ Maxilla ☐ Both Jaws



(If no teeth are selected the whole jaw will be scanned)

Is the patient coming with a radiographic template? ☐ Yes ☐ No

Is the patient possibly pregnant? ☐ Yes ☐ No

CLINICAL INDICATIONS **(mandatory)**

CBCT FORMAT		JUSTIFICATION FOR X-RAY		EXTRAS	
DICOM Files	☐	Implants	☐	Additional copy	☐
Romexis Viewer	☐	Bone Graft	☐		☐
(MAC OS and windows)	☐	Impacted Teeth	☐		☐
	☐	Endodontics	☐		☐
	☐	Sinus Exam	☐		☐
	☐	TMJ	☐		☐
	☐	Oral Pathology	☐		☐
	☐	Ortho	☐		☐

I confirm that as an "operator", in terms of interpreting images I am adequately trained in this task and accept responsibility for reporting and treatment planning.

REFERRING CLINICIAN:

Signature: Date:

PATIENT: Signature: Date: