

# Request for Dental CT Scan



Patient Ref No. \_\_\_\_\_

**Referrers are required to complete sections 1-3 accurately and legibly. Inadequately completed forms will not be accepted.**

## 1 Patient Details

Surname: \_\_\_\_\_ Forename: \_\_\_\_\_ Title: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male / Female (Delete as appropriate)

Address: \_\_\_\_\_

Post Code: \_\_\_\_\_ Tel (Home): \_\_\_\_\_ Mobile: \_\_\_\_\_

**Patient Identification:**  
For 3fivetwo  
Healthcare use only.

I have confirmed the above patients name, address and DOB.

Signed: \_\_\_\_\_

Verified by patient:  If another / Status: \_\_\_\_\_

Signed: \_\_\_\_\_

## 2 Examination details

Patient to wear stent provided by dentist?  Yes  No

CT maxilla

CT of both jaws

CT mandible

Parallel to occlusal plane

Parallel to occlusal plane

Parallel to occlusal plane

**Clinical Details / Notes:** Please include provisional diagnosis or indication and indicate results of previous tests / imaging if applicable.

You are legally obliged under IR(ME)R NI 2000 to supply sufficient medical data for justification purposes.

## 3 Referrer details

Referrer (print name): \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Post Code: \_\_\_\_\_ Email Address: \_\_\_\_\_ Tel: \_\_\_\_\_

**For operator /  
practitioner use only:**

Examination / procedure authorised by: \_\_\_\_\_ Date: \_\_\_\_\_  
(subject to a decision to proceed following completion of pregnancy status section on reverse, if relevant)

**For 3fivetwo use only:**

Appointment date and time: \_\_\_\_\_

Please send by post or fax to: **3fivetwo Healthcare** Medical Imaging Centre, 6 Lisburn Road,  
Belfast BT9 6AA T +44 (0)28 9073 5266 F +44 (0)28 9024 9929 E [imaging@3fivetwo.com](mailto:imaging@3fivetwo.com)

CT  
DENTAL

**Pregnancy Status /** This section must be completed for a female aged 12 – 55 years for procedures in which the primary X-ray beam irradiates the area between the diaphragm and upper femora.

For operator / practitioner use only

**A** Ascertain from the patient if she is:

Definitely not pregnant (Complete B & D and proceed with exposure)

Definitely pregnant (Complete B & C)

Might be pregnant (Complete B & C)

**B** Date of the first day of last menstrual period (LMP) \_  
\_\_\_\_\_

**C** Practitioner must review justification for the proposed exposure

Justified (Complete D and proceed with exposure)

Practitioner's signature: \_\_\_\_\_

Out of hours: Discussed with: \_\_\_\_\_

Operator's initials: \_\_\_\_\_ Date: \_\_\_\_\_

Not justified proceed as follows: \_\_\_\_\_

**D** Patients signature: \_\_\_\_\_

Operator's initials: \_\_\_\_\_

Date: \_\_\_\_\_

**Pharmaceutical prescription & Administration**

Name:	Strength:	Dose / quantity:	Batch no. & Expiry date:	Drawn up by:	Checked by:
Prescribers signature:			Administered by:		

**Examination / Procedure details**

Date	Examination	SOP (✓)	DLP	CTDI VOL	Radiologist(s)
					Operator(s)

**Scan reporting & dispatch**

Assigned to (Radiologist): \_\_\_\_\_  Report Sent  Disc Sent Date Sent: \_\_\_\_\_

Address sent to: \_\_\_\_\_

**Notes:**

**For 352 Admin use:** This patient is:  Insured  Self Funding  Waiting List Initiative  Employer  Occ Health / Screen

Insurance Company / Trust: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Authorisation Number: \_\_\_\_\_

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