

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: _____

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: _____