DENTALSCAN REFERRAL FORM

REFERRER DETAILS AND DELIVERY ADDRESS

Name of Referrer:

Practice name:

Address:

Telephone:

Email:

PATIENT DETAILS

Appointment Date : / / Time:

Name & Surname:

Date of Birth: / / Telephone:

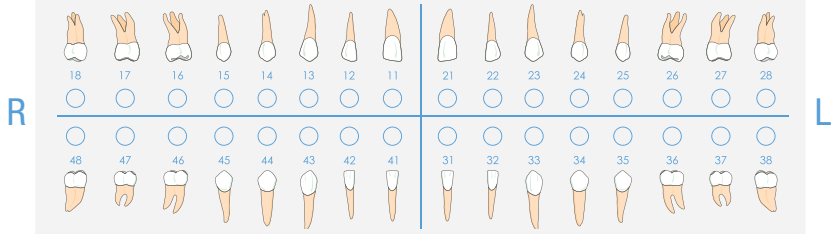
First Line of Address (required for patient identification under IRMER):

Email:

Radiographic template with patient? ☐ Denture Marked ☐ Separate Template

AREA OF INTEREST CBCT ONLY

☐ Sectional (5x5cm) ☐ Quadrant (8x6cm) ☐ Mandible (11x6cm)
☐ Maxilla (9x6cm) ☐ Ortho/Airway (23x17cm) ☐ Both Jaws (9x10cm)
☐ Both Jaws + Full Sinuses (9x13cm) ☐ Maxilla + Full Sinuses (9x8cm)



CBCT FORMAT

☐ i-CAT Vision
☐ Cloud Viewer (PACS)
☐ DICOM Files
☐ SimPlant
☐ SimPlant OneShot
☐ NobelClinician
☐ InVivo6 Viewer

2D IMAGING

☐ Panoramic (OPG/OPT)
☐ Lateral Ceph CEPH
☐ PA Ceph CEPH
☐ Bitewings

EXTRAS

☐ Express Processing
☐ Ceph Tracing Report
☐ Extra copy

iTERO - INTRA ORAL

☐ Invisalign Upload
☐ .STL Secure Link

PAYMENT

☐ Practice
☐ Patient

JUSTIFICATION FOR X-RAY

☐ Implants
☐ Bone Grafting
☐ Impacted Teeth
☐ Endodontics
☐ Perio
☐ Airway Assessment
☐ Sinus Exam
☐ TMJ
☐ Oral Pathology
☐ Ortho

CBCT OUTPUT

☐ Secure Link
☐ CD
☐ PDF
☐ Photopaper

2D OUTPUT

☐ Secure Link (JPG)
☐ DICOM Files
☐ Cloud Viewer (PACS)
☐ Photopaper

RADIOLOGY REPORT

☐ Rule out Pathology
☐ Implant Planning
☐ Highlight ID Canal
☐ Implant Measurements
☐ 24-Hour Report

CLINICAL INDICATIONS (mandatory)

SIGNATURE

DATE

/ /

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Our radiographers will always base the scanning protocol (field of view, resolution and expoosure settings) on the justification for referral, age and anatomy of the patient.