Dental CBCT Request Form

PRIORY DENTAL CARE

Patient Details

Title: First Name: Surname:

Address:

Postcode:

Date of Birth: Email:

Telephone: Mobile:

Referring Dentist Details

Dentist Name: GDC No:

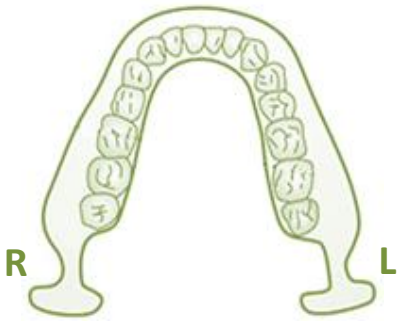
Practice Address:

Postcode: Telephone:

Email:

Justification for CBCT:

CBCT Scan Requirements



All scans will be parallel to the occlusal plane unless otherwise specified.

Field of View (please tick one of the following options):

- ☐ Full Upper (80x55mm approx)
- ☐ Full Lower (80x55mm approx)
- ☐ Full Upper and Lower (80x80mm)
- ☐ Upper Sectional (50x50mm) Please mark area on diagram
- ☐ Lower Sectional (50x50mm) Please mark area on diagram
- ☐ Lower Wisdom Tooth Sectional (80x55mm approx) Please mark area on diagram
- ☐ Endo (50x50mm FOV only) Please state tooth notation in Justification. *Standard image resolution will be supplied unless you specifically request High Resolution* ☐ High Resolution Endo required

CBCT Scan Fee £115 *(as at 01/01/2026)*

☐ I understand that, as the referrer, I undertake to report on the scan, as per IR(ME)R 2017 requirements. As the referrer, I am also responsible for ensuring the clinical evaluation takes place and is properly recorded.

Referring Dentist Signature: Date:

Priory Dental Care, 5 Priory Road, Downham Market, Norfolk, PE38 9JU
☎ 01366 386666 | ✉ info@priory-dental.co.uk | 🌐 www.priory-dental.co.uk