the berkeleyclinic
Committed to Excellence
Award winning centre for Cosmetic Dentistry, Dental Anxiety and Dental Implants

Sirona xG 3D Dental CT & Digital OPT Examination Request Form

☐ Mr ☐ Mrs ☐ Ms Other _____

Surname:
Forename(s):
Address:

Post Code:

Date of Birth:
Home Tel No:
Work Tel No:
Mobile No:
Email:
Best Time To Call:

Referring Practitioner details:

☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Dr

First Name
Surname
GDC No
E-mail
Signature dsbsdfhgsfdgh

Date of Referral
Address

City/Town
Post Code
Telephone No
Fax No

Region of specific clinical interest

8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1 | 1 2 3 4 5 6 7 8

Proposed course of treatment - including details of proposed number & location of implants

Clinical reason for referral and justification for XG 3D CT Scan or Digital OPT

Date of Request

Examination Request for *XG 3D Dental CT*

Please tick area(s) for CT scan

☐ Complete Maxilla ☐ Complete Mandible
☐ Maxilla & Mandible

Quadrant ☐ ☐ ☐ ☐

SICAT stent required ☐ Yes ☐ No
Volume Size ☐ 8x8 ☐ 5x5
High Definition ☐ Yes ☐ No

Image Management for *XG 3D Dental CT*

☐ CT scan in Galileos viewer format on CD

☐ CT scan in Dicom file CD (for Nobel Guide, SimPlant)

Image Management for *Digital OPT*

☐ OPT on photographic paper

☐ OPT on CD

☐ OPT as e-mail attachment

☐ Full jaw scan

Sectional Scan ☐ ☐ ☐ ☐

TOP COPY TO GO TO THE BERKELEY CLINIC **BOTTOM COPY** FOR YOUR RECORDS

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www.berkeleyclinic.com

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Relevant results of history, clinical examination and other imaging

I would like to make this patients radiographic examination to be reported upon by you/I will make my own reporting arrangements (DELETE AS APPLICABLE).

Justification
Name of IRMER practitioner:
Signature
Date:
Details of scan authorised:

Scan information:
Name of Operator:
Signature:
Date of scan:
Exposure factors used:

Clinical evaluation (Reporting)
Name of Operator (Reporting)
Signature:
Date:
Outcome:

ON COMPLETION, RETAIN THIS FORM AND RETURN A COPY TO THE REFERRING PRACTICE

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