Toothwise – Hurworth Dental Practice
5 Church Row
Hurworth
Darlington
DL2 2AQ

CBCT Referral Form

Please complete and return to dental.v01293@nhs.net or the practice address above.

Dear referrer – please be aware that Toothwise Hurworth Dental Practice does not offer a CBCT reporting service. It is the responsibility of the referring practitioner to organise a reporting service with an accredited professional.

Referring Dentist Details	
Name	
GDC Number	
Practice Address	
Postcode	
Telephone Number	
Email Address	

Patient Details	
Name	
Date of Birth	
Address	
Postcode	
Telephone Number	
Email Address	

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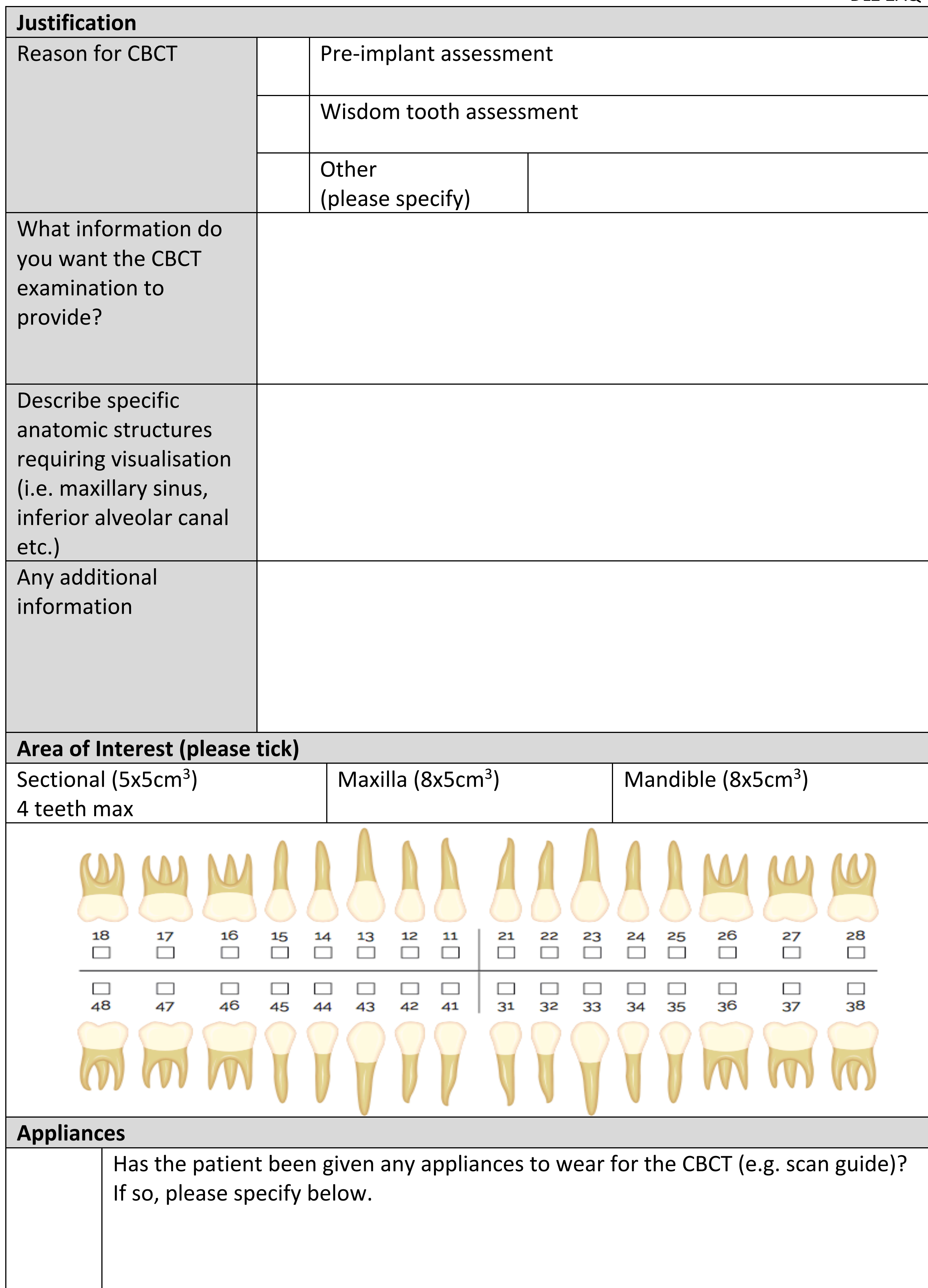

Justification			
Reason for CBCT		Pre-implant assessment	
		Wisdom tooth assessment	
		Other (please specify)	
What information do you want the CBCT examination to provide?			
Describe specific anatomic structures requiring visualisation (i.e. maxillary sinus, inferior alveolar canal etc.)			
Any additional information			

Area of Interest (please tick)		
Sectional (5x5cm^3) 4 teeth max	Maxilla (8x5cm^3)	Mandible (8x5cm^3)

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
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48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Appliances	
	Has the patient been given any appliances to wear for the CBCT (e.g. scan guide)? If so, please specify below.

Reporting of Scan (please tick)	
	I confirm I am a qualified IRMER referrer (minimum CBCT Level 1 Core Training) and I am aware that Toothwise Hurworth Dental Practice will not be providing a reporting service of the CBCT request*

*WE REQUEST ALL NEW REFERRING PRACTITIONERS TO PROVIDE EVIDENCE OF CBCT LEVEL 1 CORE TRAINING CERTIFICATE WITH THIS REFERRAL FORM

Service Level Agreement for the Referral of Patients To Hurworth Dental Practice for Dental CBCT Examinations	
This agreement is between:	
Hurworth Dental Practice 5 Church Row Hurworth Darlington Co. Durham DL2 2AQ 01325 721999 dental.v01293@nhs.net	Clinician: Address: Postcode: Tel: Email:
GDC number	

Justification (please tick)	
	I agree to use the referral criteria as per the European Guidelines: Radiation Protection No. 172 and provide adequate clinical information in order for each examination to be justified
Reporting (please tick one of the following)	
	I will make my own arrangement for the reporting of my Cone Beam CT scans acquired at Toothwise – Hurworth Dental Practice. This will be done by someone adequately trained as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT
	I will report my Cone Beam CT scans acquired at Toothwise – Hurworth Dental Practice. I confirm that I am adequately trained to interpret cone beam CT scans as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT. I will ensure that my training remains up to date
These guidelines are available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340159/HPA-CRCE-010_for_website.pdf	

Hurworth Dental Practice		**Referring Clinician**	
Signature		Signature	
Date		Date	