

CBCT – Referral Form



Hollybush Dental Clinic
17 Hollybush Road,
Crawley, West Sussex,
RH10 8DU

E: reception.hollybush@
colosseumdental.co.uk

colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above. You can also book online via our website. If you have any questions, please feel free to give us a call on 01293 526861

Patient Details

Name	
DOB	
Address	
Telephone	
Email	

Referring Dentist Details

Name	
GDC No.	
Practice address	
Telephone	
Email	
Signature	

Scan details

Type of Scan	<input type="checkbox"/> Cone Beam CT	<input type="checkbox"/> OPG/OPT
Scan Size (please indicate area on Diagram)	<input type="checkbox"/> Sectional <input type="checkbox"/> Quadrant <input type="checkbox"/> Mandible (Lower Jaw) <input type="checkbox"/> Mandible (Upper Jaw) <input type="checkbox"/> Both Jaws (If no teeth specified, full jaw will be scanned)	
CBCT Output Format	<input type="checkbox"/> DICOM file	<input type="checkbox"/> CS 3D Imaging Simple Browser
Justification for scan		
Scan template to be fitted	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I will provide my own radiographic report	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Fees (£150 per arch/sextant for CBCT and £50 for OPT)

Please indicate who will pay for scan	<input type="checkbox"/> Patient	<input type="checkbox"/> Referrer	
For scan (plus cost of report)	<input type="checkbox"/> £150 (CBCT)	<input type="checkbox"/> £50 (OPG/OPT)	<input type="checkbox"/> £75 (report)

Please note: It is the referring practitioner's responsibility to ensure that all scans and radiographs are reviewed and reported appropriately in the clinical records, in compliance with IRMER 2000 regulations.

It is strongly recommended that all scans/radiographs are reported upon by appropriately trained individual to assess for any coincidental pathology.

Please let us know if you wish to make your own arrangements for the reporting.

CBCT – Referral Form



Cambourne Dental Clinic
Monkfield House, Monkfield Lane,
Great Cambourne,
Cambridgeshire, CB23 6AJ

E: reception.cambourne@colosseumdental.co.uk

colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above. You can also book online via our website. If you have any questions, please feel free to give us a call on 01954 718585

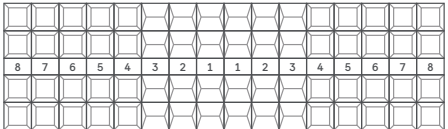
Patient Details

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Email	

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GDC No.	
Practice address	
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Email	
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CBCT – Referral Form



Gravesend Dental Clinic
43 The Grove,
Gravesend, Kent,
DA12 1DP

E: reception.gravesend@
colosseumdental.co.uk
colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above. You can also book online via our website. If you have any questions, please feel free to give us a call on 01474 333367

Patient Details

Name	
DOB	
Address	
Telephone	
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Referring Dentist Details

Name	
GDC No.	
Practice address	
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Scan details

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CBCT – Referral Form



Mawsley Dental Clinic
 Medical Centre, School Road,
 Kettering, Northamptonshire,
 NN14 1SN

E: reception.mawsley@
 colosseumdental.co.uk

colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above. You can also book online via our website. If you have any questions, please feel free to give us a call on 01536 799210

Patient Details

Name	
DOB	
Address	
Telephone	
Email	

Referring Dentist Details

Name	
GDC No.	
Practice address	
Telephone	
Email	
Signature	

Scan details

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CBCT – Referral Form



Church Hill Dental Clinic
Church Hill, Midhurst,
West Sussex,
GU29 9NX

E: reception.churchhill@
colosseumdental.co.uk

colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above. You can also book online via our website. If you have any questions, please feel free to give us a call on 01730 810010

Patient Details

Name	
DOB	
Address	
Telephone	
Email	

Referring Dentist Details

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GDC No.	
Practice address	
Telephone	
Email	
Signature	

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CBCT – Referral Form



Little London Dental Clinic
31 Little London, Chichester,
West Sussex, PO19 1PL

E: reception.littlelondon@
colosseumdental.co.uk

colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above.
You can also book online via our website. If you have any questions, please feel free to give us a call on 01243 782878

Patient Details

Name	
DOB	
Address	
Telephone	
Email	

Referring Dentist Details

Name	
GDC No.	
Practice address	
Telephone	
Email	
Signature	

Scan details

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CBCT – Referral Form



**Hanlon and Gardner
Dental Practice**
30 New Road, Chippenham,
Wiltshire, SN15 1HP

reception.chippenham@
colosseumdental.co.uk

colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above.
You can also book online via our website. If you have any questions, please feel free to give us a call on 01249 652259

Patient Details

Name	
DOB	
Address	
Telephone	
Email	

Referring Dentist Details

Name	
GDC No.	
Practice address	
Telephone	
Email	
Signature	

Scan details

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CBCT – Referral Form



**Arnot Hill
Dental Clinic**
82–84 Nottingham Road,
Nottingham, NG5 6LF
reception.arnothill@
colosseumdental.co.uk
colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above. You can also book online via our website. If you have any questions, please feel free to give us a call on 0115 926 5822

Patient Details

Name	
DOB	
Address	
Telephone	
Email	

Referring Dentist Details

Name	
GDC No.	
Practice address	
Telephone	
Email	
Signature	

Scan details

Type of Scan	<input type="checkbox"/> Cone Beam CT	<input type="checkbox"/> OPG/OPT
Scan Size (please indicate area on Diagram)	<input type="checkbox"/> Sectional <input type="checkbox"/> Quadrant <input type="checkbox"/> Mandible (Lower Jaw) <input type="checkbox"/> Mandible (Upper Jaw) <input type="checkbox"/> Both Jaws (If no teeth specified, full jaw will be scanned)	
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CBCT – Referral Form



Kenton Dental Centre
607 Kenton Road
Harrow, HA3 9RT

appointments.kenton@
colosseumdental.co.uk

colosseumdental.co.uk

Please make a referral by completing the form below and sending back to us using the contact details above. You can also book online via our website. If you have any questions, please feel free to give us a call on 0208 204 5511

Patient Details

Name	
DOB	
Address	
Telephone	
Email	

Referring Dentist Details

Name	
GDC No.	
Practice address	
Telephone	
Email	
Signature	

Scan details

Type of Scan	<input type="checkbox"/> Cone Beam CT	<input type="checkbox"/> OPG/OPT
Scan Size (please indicate area on Diagram)	<input type="checkbox"/> Sectional <input type="checkbox"/> Quadrant <input type="checkbox"/> Mandible (Lower Jaw) <input type="checkbox"/> Mandible (Upper Jaw) <input type="checkbox"/> Both Jaws (If no teeth specified, full jaw will be scanned)	
CBCT Output Format	<input type="checkbox"/> DICOM file	<input type="checkbox"/> CS 3D Imaging Simple Browser
Justification for scan		
Scan template to be fitted	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I will provide my own radiographic report	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Fees (£100 per arch/sextant for CBCT and £50 for OPT)

Please indicate who will pay for scan	<input type="checkbox"/> Patient	<input type="checkbox"/> Referrer	
For scan (plus cost of report)	<input type="checkbox"/> £150 (CBCT)	<input type="checkbox"/> £50 (OPG/OPT)	<input type="checkbox"/> £75 (report)

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