

CBCT Referral Form

Referring Clinician:

Name

Name of Practice

Practice Address

Address Line 2

Postcode

Telephone Number

Email Address

Preferred method of receiving report

USB

Web Transfer

Patient Details:

Title

First Name

Surname

D.O.B (dd/mm/yyyy)

Address

Postcode

Preferred Contact Number

Email Address

Medical History of Note

Area of interest for CBCT

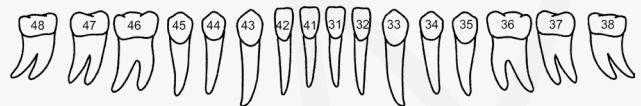
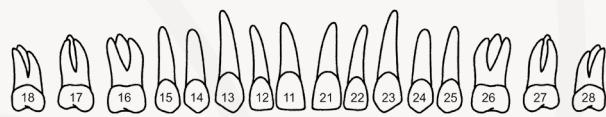
Small Volume

Sectional/Quadrant

Mandible

Maxilla

Full Mouth



Is the patient coming with a radiographic template?

Yes

No

Is the patient possibly pregnant?

Yes

No

IF NO TEETH ARE
SELECTED THE
WHOLE JAW WILL
BE SCANNED.
PLEASE INDICATE
THE CBCT SCAN
SIZE YOU REQUIRE.

Justification for X-ray

Clinical Details

Implants	TMJ
Bone Graft	Oral Pathology
Impacted Teeth	Orthodontics
Endodontics	Zygomatic Implants
Sinus Exam	Other

THE RADIOGRAPHERS AT LINK HOUSE WILL TAKE A SCAN WITH THE LOWEST DOSE, SMALLEST FIELD OF VIEW & BEST RESOLUTION ACCORDING TO AREA OF INTEREST & REASON FOR SCAN (IRMER + ALARP). THE AGE, ANATOMY, PHYSICAL SIZE & BODY MASS OF A PATIENT ARE ALL INDEPENDENT FACTORS THAT NEED TO BE TAKEN INTO CONSIDERATION IN YOUR PRESCRIPTION. PLEASE ALLOW 7 - 10 DAYS FOR REPORTING. IF YOU NEED THE CBCT REPORTED ON MORE URGENTLY, THEN AN EXPRESS SERVICE IS AVAILABLE.

FIELD OF VIEW	SCAN	
	180°	360°
Ø40 x H40	NOT AVAILABLE	HIGH RESOLUTION
Ø40 x H40		
Ø40 x H80		
Ø80 x H40		
Ø80 x H50		
Ø80 x H80		
Ø100 x H40		NOT AVAILABLE
Ø100 x H50		
Ø100 x H80		

GUIDELINES FOR FINDING THE APPROPRIATE SIZING FOR CBCT REQUESTS.

Ø40
FOR 2 OR 3 TEETH OR THE TMJ.
X-ray dosage is very low because exposure is localized.



Ø80
FOR THE ENTIRE DENTAL ARCH.
Wisdom teeth or the back molar might not appear in the image.



Ø100
MORITA'S UNIQUE FOV THAT FITS THE DENTAL ARCH.
An image of the entire dental arch is made with a lower x-ray dosage.

*for patients with large jaws, the whole region might not be in the exposure.

360° EXPOSURE ANGLE WILL REDUCE SCATTER ARTEFACT OF RADIOPAQUE OBJECTS INSIDE AND OUTSIDE THE FIELD OF VIEW. 360° EXPOSURE WILL BE APPROXIMATELY DOUBLE THAT OF A 180° EXPOSURE.

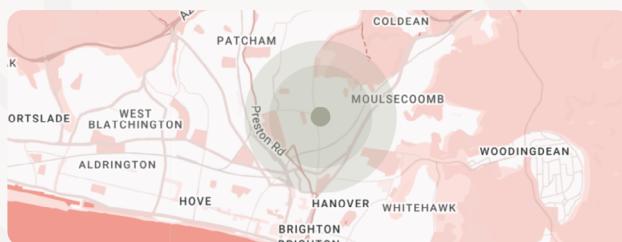
Payment

Dentist

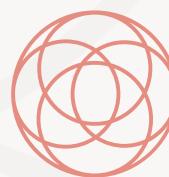
Patient

Signature

I confirm I have the patient's consent to share their details and clinical data with Link House



 care@linkhousecentre.co.uk
 [01273 044 990](tel:01273044990)
 www.linkhousecentre.co.uk



LINK
HOUSE

We aim to contact patients within 24 hours of receiving the referral.

For multidisciplinary referrals, please provide as much detail as possible to ensure we direct the patient to the appropriate clinician.

Once treatment is successfully completed, the patient will be returned to you for continued care.