Northlight
DENTAL

6 The Square Aspley Guise MK17 8DF T: 01908 584461 F: 01908 584715 E: info@northlightdental.co.uk

CBCT Scan Referral Form

Referring Practitioner

Name

Practice

Address

Tel

Email

Patient Details

Name

Date of birth

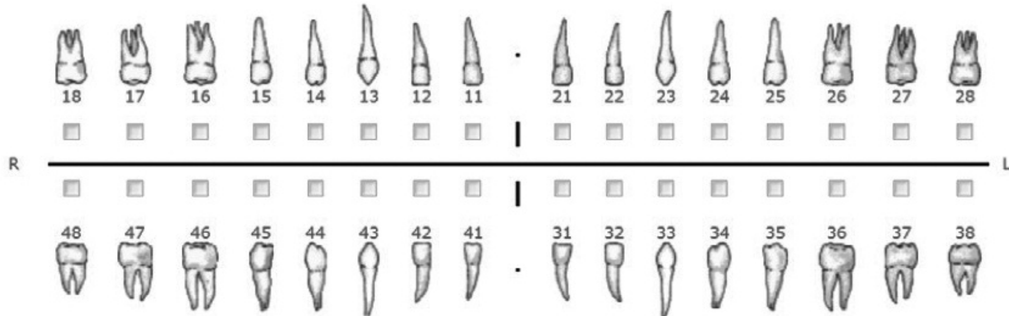
Address

Tel

Email

Area of interest ◯ Mandible ◯ Maxilla ◯ Both jaws

◯ Localised 5x5cm scan: 4-6 teeth dependent on the area of the jaw. Please mark area below.



◯ Patient to wear radiographic stent during scan

Justification for scan ◯ Implants ◯ Impacted teeth ◯ Endodontics ◯ Sinus exam ◯ Orthodontics ◯ Other

Clinical indications (required in all cases)

Format required ◯ CD ◯ Email (eg. Dropbox)

Extras (please enquire for prices) ◯ Simplant conversion ◯ Radiologist report

Referrer's signature

Date

Thank you for your valued referral. www.northlightdental.co.uk