Woodborough HOUSE
REFERRAL PRACTICE

REFERRAL FORM

www.woodboroughhouse.co.uk

DENTIST DETAILS & DELIVERY ADDRESS

DENTIST NAME

PRACTICE

ADDRESS

TELEPHONE

EMAIL

PATIENT DETAILS

NAME

ADDRESS

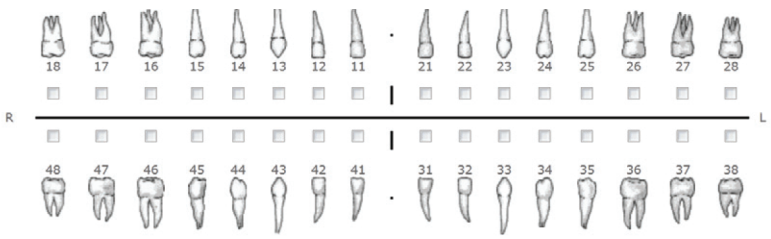
DATE OF BIRTH

TELEPHONE (MOBILE)

EMAIL

AREA OF INTEREST - CBCT ONLY

☐ ENDO ☐ SECTIONAL/ QUADRANT ☐ MANDIBLE ☐ MAXILLA ☐ BOTH
☐ FULL MOUTH INCLUDING ZYGOMATIC PROCESS



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. THE WHOLE JAW WILL BE SCANNED IF YOU DO NOT ADVISE OTHERWISE.

CBCT OUTPUT

☐ DVD ROM OR USB
☐ WEB TRANSFER

2D OUTPUT

☐ DVD ROM OR USB
☐ WEB TRANSFER & EMAIL

2D IMAGING

☐ FULL OR PARTIAL PANORAMIC X-RAYS
☐ PERI-APICAL X-RAYS
☐ BITE WING X-RAYS
☐ PANORAMIC SCANNING OF THE MAXILLARY SINUS
☐ PANORAMIC SCANNING OF THE TMJ
☐ PANORAMIC BITE WINGS
☐ LATERAL CEPH X-RAYS
☐ HAND DEVELOPMENT X-RAYS
☐ INTRAORAL SCANNING
☐ MODJAW SCANNING
☐ PHOTOGRAPHY

JUSTIFICATION FOR X-RAY
(MANDATORY)

☐ IMPLANTS
☐ BONEGRAFT
☐ IMPACTED TEETH
☐ ENDODONTICS
☐ SINUS EXAM
☐ TMJ
☐ ORAL PATHOLOGY
☐ ORTHODONTICS
☐ ZYGOMATIC IMPLANTS & OTHER
☐ OTHER _____

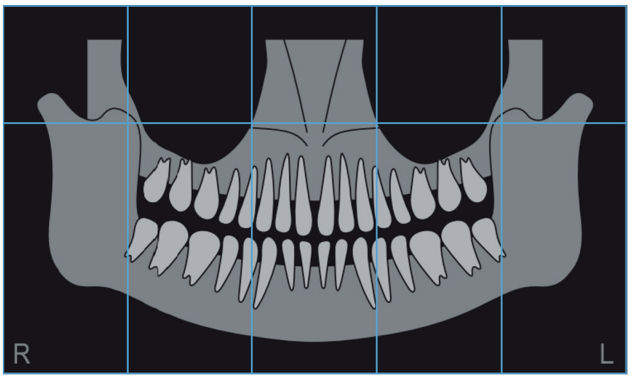
CLINICAL INDICATIONS
(MANDATORY)

OPG X-ray (Orthopantomography)

PLEASE INDICATE THE AREAS OF THE PANORAMIC X-RAY WHICH ARE OF PARTICULAR INTEREST. PLEASE INDICATE THOSE AREAS THAT ARE NOT OF DIAGNOSTIC INTEREST. FOR EXAMPLE – DO YOU REQUIRE ALL AREAS OF THE TEETH AND JAWS? DO YOU REQUIRE THE TMJS OR SINUSES FOR DIAGNOSIS? IF NOT, WE CAN AVOID SCANNING THESE REGIONS.

PLEASE ADVISE WHICH REGIONS YOU REQUIRE:

☐ STANDARD (STD), WHAT YOU SEE IN THE ADJACENT CHART
☐ PARTIAL (PRTL), PLEASE INDICATE AREAS OF INTEREST ON THE ADJACENT CHART
☐ HIGH-SPEED (HS) OR ☐ HIGH DEFINITION (HD)
HIGH-SPEED = LOWER EXPOSURE, BUT LESS DEFINITION



PLEASE NOTE

THE RADIOGRAPHERS AT WOODBOROUGH 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*.

21 READING ROAD PANGBOURNE BERKSHIRE RG8 7LR | T 0118 984 3108 | E INFO@WOODBOROUGHHOUSE.COM | WWW.WOODBOROUGHHOUSE.COM

PLEASE MARK ON THE FORM, ADVISING WHAT SIZE CBCT SCAN YOU REQUIRE. THIS WILL AFFECT THE PRICE OF THE SCAN AND THE REPORT.

FIELD OF VIEW (FOV)	SCAN (SCAN)		RESOLUTION (RES)	
	180°*	360°*	HR** (high resolution)	SD (standard)
ø40 x H40				
ø40 x H80			NOT AVAILABLE	
ø80 x H40			NOT AVAILABLE	
ø80 x H50				
ø80 x H80				
ø100 x H40		NOT AVAILABLE	NOT AVAILABLE	
ø100 x H50				
ø100 x H80				
ø150 x H50		NOT AVAILABLE	NOT AVAILABLE	
ø150 x H75				
ø150 x H140				

* 360° VS 180° EXPOSURE ANGLE. 360° EXPOSURE ANGLE WILL REDUCE SCATTER ARTEFACT OF RADIOPAQUE OBJECTS INSIDE AND OUTSIDE THE FIELD OF VIEW. 360° EXPOSURE ANGLE WILL BE APPROXIMATELY DOUBLE THAT OF A 180° EXPOSURE ANGLE.
** CAN YOU PLEASE INDICATE FOR ENDODONTIC SCANS IF YOU REQUIRE A SCAN IN STANDARD (SD) OR HIGH RESOLUTION (HR). SD/HR

GUIDELINES FOR FINDING THE APPROPRIATE SIZING FOR CBCT REQUESTS.
FOR MORE DETAILED ADVICE PLEASE REFER TO OUR INFORMATION BOOKLET PDF.

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

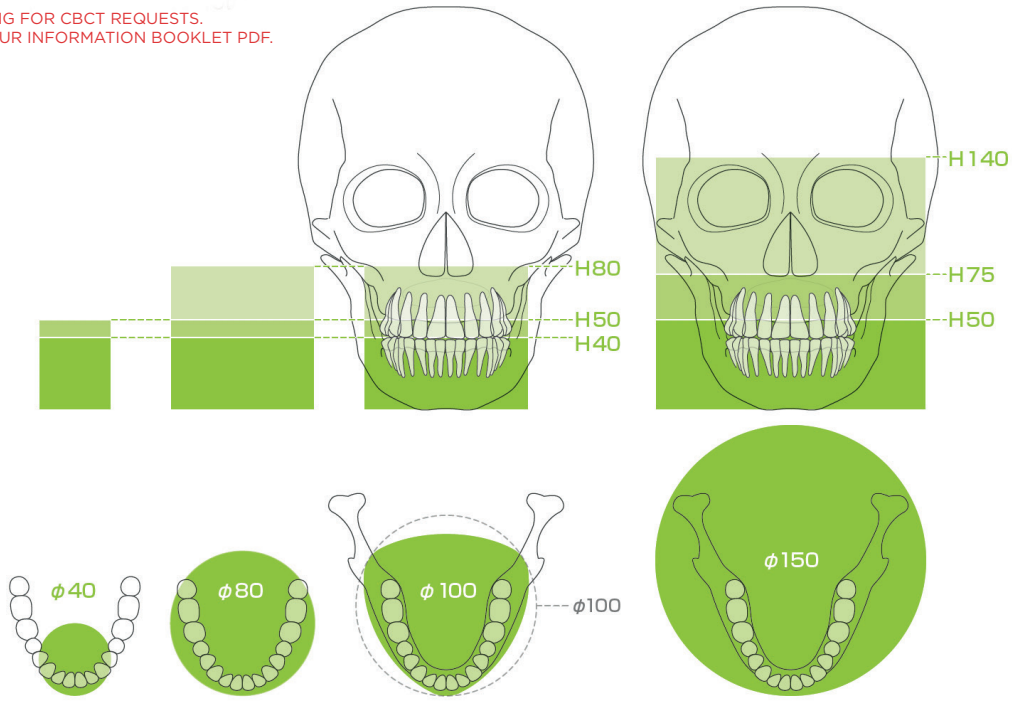
MORITA'S UNIQUE FOV THAT FITS THE DENTAL ARCH.

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.

Ø100

THIS EXPOSES THE ENTIRE JAW AREA. THE H140 EXPOSURE COMBINES TWO EXPOSURES AND EXPANDS THE EXPOSURE RANGE TO THE ENTIRE JAW AND FACIAL AREA.



PAYMENT ☐ DENTIST ☐ PATIENT

SIGNATURE

PLEASE NOTE

MANDATORY REPORTING IS UNDERTAKEN ON ALL OF THE CBCT SCANS THAT ARE TAKEN AT WOODBOROUGH HOUSE IMAGING SOLUTIONS. THIS IS PROVIDED BY AN INDEPENDENT DENTAL RADIOLOGY SERVICE. THE FEE FOR THIS IS INCLUDED IN THE SCANNING FEE AND A COPY OF THE REPORT IS SENT TO THE REFERRING DENTIST.

SERVICE-LEVEL AGREEMENT FOR THE REFERRAL OF PATIENTS TO WOODBOROUGH HOUSE DENTAL PRACTICE FOR CONE BEAM CT EXAMINATIONS

Name and Address of Cone Beam CT Practice:
Woodborough House Dental Practice, 21 Reading Road, Pangbourne, Reading, Berkshire RG8 7LR

CT Practice Telephone: 01189 843108 **CT Practice Email:** referral@woodboroughhouse.com

CT Practice Employer: Sarah Fitzharris

Name and Address of Referring Practice:

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_____

_____

_____

Referring Practice Telephone: _____ **Referring Practice Email:** _____

Referring Practice Employer: _____

Referral criteria for dental cone beam CT:

The document specified below will be used by both parties as the basis for the referral of patients and the justification/authorisation of dental cone beam CT examinations:

> The Faculty of General Dental Practitioners "Selection Criteria for Dental Radiography"
> The British Orthodontic Society – Orthodontic Guidelines
> Chapter 4 of the SEDENTEXCT European Guidelines on Cone Beam CT for Dental and Maxillofacial Radiology13
> Chapter 3 of the European Guidelines on Radiation Protection in Dental Radiology 14

Entitlement of Persons

Enter below details of all persons at the referring practice who will refer patients for dental cone beam CT examinations and/or report on dental cone beam CT images. Evidence of training meeting the requirements of the HPA/British Society of Dental and Maxillofacial Radiology (BSDMFR) Core Curriculum in Dental CBCT15 must be provided.

FOR COMPLETION BY THE REFERRING PRACTICE				FOR COMPLETION BY CONE BEAM CT PRACTICE	
NAME	GDC/GMC REG NO.	(IRMER ROLES) REFERRER	(IRMER ROLES) OPERATOR (REPORTING)	TRAINING OK?	REGISTRATION OK?

Signatures of agreement:

We the undersigned agree: (1) to use the referral criteria stated above; (2) that evidence of adequate training has been provided for each of the persons named above appropriate to their IRMER roles; (3) that adequate information will accompany each referred patient to allow the justification process to proceed, as set out in the attached Imaging Referral Form.

For the cone beam CT practice:

EMPLOYEE SIGNATURE	CT PRACTICE SIGNED DATE

For the referring practice:

EMPLOYEE SIGNATURE	REFERRER PRACTICE SIGNED DATE