



Perlan Specialist Dental Centre Dental CT Request Form

PLEASE FAX COMPLETED FORM TO 01323 432193

Patient details

Patient name	Tel (H)	<input type="checkbox"/>
First.....Title.....	Tel (W)	<input type="checkbox"/>
Last..... Initials.....	Tel (M)	<input type="checkbox"/>
DoB.....	email	<input type="checkbox"/>
Patient Address	Please tick preferred contact method	
.....	Notes:	
.....	
.....Postcode.....	

Referrer details

Name

Practice Address

.....

.....

.....Postcode.....

Tel

email

Reason for scan and justification

.....

.....

.....

.....

.....

.....

Scan requirements

Patient to wear radiographic template?

Yes No

Specific region of interest:

.....

.....

.....

Invoice to

Practice Patient

Scan Format

DICOM data on CD

CD with viewing software

Send to 3rd party for processing (give details)

.....