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| **CBCT Referral Form**  **68 Southover, Woodside Park, North Finchley, London, N12 7HB.**  **Phone: 0208 445 6949**  **Website:** [**http://www.kletzandsher.com**](http://www.kletzandsher.com/) | | | | |
| Referrer Name: |  | Patient Ref #: | |  |
| Patient Name: |  | Patient DOB: | |  |
| Patient Address: |  | | | |
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|  | | | |
| Clinical History: |  | | | |
| Clinical question to be answered: |  | | | |
| Requested Region/s: |  | | | |
| Referrer Signature: | *Only registered health care professionals can refer for imaging* | | Date of referral: | |
| **Cost of Scan:** | **£200(unreported) including 1 x copy on a disc** | | | |
| **Patient Statement:** | ***I have been informed regarding the clinical benefit of the x-ray, know what is involved and understand the x-ray risks involved and I wish to proceed.*** | | | |
| **Patient Signature:** |  | | | |
| **Practitioner JUSTIFICATION** checks  or Operator AUTHORISATION: | | | | |
| **Any Operator notes** (e.g. exposure factors, any known artefacts or inabilities to achieve imaging for any reason): | | | | |