

Cone Beam CT Imaging Referral

Patient Details

Surname: _____ First Name: _____
D.O.B: _____ Email: _____
Address: _____

Tel (Home): _____ Tel (Mobile): _____

Reason for Referral

Scan Requested (Please tick)

Maxilla 6cm scan Mandible 6 cm scan 2 arch 8cm scan 2 arch 13 cm scan

ALL SCANS ARE CARRIED OUT PARALLEL TO THE OCCLUSAL PLANE

Format Options (Please tick)

- | | | | | |
|--|---------|----------|------------------------------------|---------|
| <input type="checkbox"/> i-CAT vision (incl software) | 1 jaw | £ 200.00 | <input type="checkbox"/> Both Jaws | £250.00 |
| <input type="checkbox"/> SimPlant Planner: | 1 jaw | £ 295.00 | <input type="checkbox"/> Both Jaws | £410.00 |
| <input type="checkbox"/> SimPlant Advanced: | 1 jaw | £ 475.00 | <input type="checkbox"/> Both Jaws | £630.00 |
| <input type="checkbox"/> SimPlant OneShot (additional fee per SimPlant case) | £200.00 | | | |

Referrer Details

Dentist: _____
GDC no: _____
Address: _____

Email: _____
Tel Practice: _____ Tel Other: _____

Signature: _____

Payment method

Patient pays (cash/card only) Invoice to dentist

- Please send or email the completed form to New Tec Dental Scanning Coordinator.
We will contact the patient to arrange a mutually convenient appointment.
- All i-CAT Vision images are supplied to you on CD ready for you to view on your own PC.
- All SimPlant images are supplied via IDT Imaging unless you specify otherwise.