

PRACTITIONER DETAILS & DELIVERY ADDRESS

Name of Practitioner:
Practice name:
Address:
Telephone:
Email:

AREA OF INTEREST CBCT ONLY

Is the patient coming with a radiographic template? ☐ Yes ☐ No
Is the patient possibly pregnant? ☐ Yes ☐ No

☐ Mandible
☐ Maxilla
☐ Both Jaws
☐ Sectional/
quadrant

(If no teeth are selected the whole jaw will be scanned)

CBCT FORMAT

☐ PACS Cloud Viewer (no software download, works on any device including mobile & tablets)
☐ i-CAT Vision ☐ DICOM Files ☐ Romexis Viewer (Mac & Windows)
☐ SimPlant Planner ☐ SimPlant OneShot ☐ SimPlant View
☐ MGUIDE ☐ iDent Protocol ☐ Nobel-Guide

CBCT FORMAT

☐ Cloud & Email ☐ CD ☐ Photo Paper

EXTRAS

☐ Express Processing ☐ Extra copy ☐ Pathology Report ☐ Radiology Report

2D IMAGING

☐ Digital Panoramic (OPG)
☐ Digital Cephalometric
☐ Ceph Tracing Report

2D OUTPUT

☐ FTP & Email
☐ PACS Cloud Viewer
☐ Photo Paper

CLINICAL INDICATIONS: (mandatory)

Signature	

PATIENT DETAILS

Appointment Date: / /	Time:
Forename & Surname:	
Date of Birth: / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Telephone:	
Payment	<input type="checkbox"/> Doctor <input type="checkbox"/> Patient

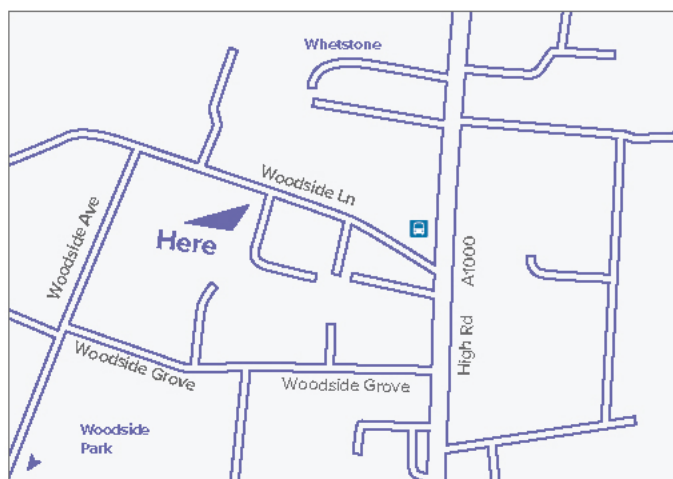
INTRA ORAL SCANNING - TRIOS 3 COLOUR

☐ Digital Impression ☐ Orthodontic Aligners
☐ Mandible ☐ Maxilla ☐ Both Jaws

☐ Radiographic Template

Please tick the radiopaque area required

IMAGES WILL BE RETURNED IN STL FORMAT



The Radiographer at CT Dent will take a scan with the lowest dose, smallest field of view and best resolution, according to the area of interest and clinical indications, in line with IR(ME)R and ALARP. The age, anatomy and physical build of the patient are all dependent factors.