Service-Level Agreement for the referral of patients to YOUR CENTRE for Dental Cone Beam CT Examinations

This agreement is between:

Revital Dental Care 4 Shaftesbury Parade Harrow, HA2 0AJ Tel: 0208 422 2120 Fax: 0208 422 6079 Email: smile@revitaldental.com	The Clinician Name: Address: Tel: Email: GDC No:

Justification:

☐ I agree to use the referral criteria as per the European Guidelines: Radiation Protection No. 172 and provide adequate clinical information in order for each examination to be justified.

Reporting:

Please tick one of the following:

☐ I would like my Cone Beam CT to be reported by JM Radiology. The service will be provided by Dr J Makdissi, Consultant in Dental and Maxillofacial Radiology.

☐ I would like Dr P Amin to carry out the repor ting of my Cone Beam CT scans acquired at Revital Dental Care . Dr Amin has been adequately trained as per HPA- CRCE-010- Guidance on the safe use of Dental Cone Beam CT

☐ I will report my Cone Beam CT scans acquired at Revital Dental Care . I confirm that I am adequately trained to interpret cone beam CT scans as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT. I will ensure that my training remains up to date.

These guidelines are available on
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340159/HPA-CRCE-010_for_website.pdf

If you need any help filling this agreement please do not hesitate to contact us.

For The Cone Beam CT Centre	For the clinician
Signature:	Signature:
Date:	Date: