

PLANMECA ULTRA LOW DOSE

CT SCANNER



Referral Form

Online booking for patients now available on:
www.smilecliniq.com/UltraLowDose_CTscanner_London.php

PRACTITIONER DETAILS & DELIVERY ADDRESS

Name of Practitioner:

Practice name:

Address:

Telephone:

Email:

PATIENT DETAILS

Forename & Surname:

Date of Birth: / / Male Female

Telephone:

PAYMENT Doctor Patient

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)

(IF REFERRAL)

Doctor Name:

Practice Name:

Practice Address:

Practice Email:

INTRA ORAL SCANNING - TRIOS 3 COLOUR

Digital Impression Orthodontic Aligners
 Mandible Maxilla
 Both Jaws

CBCT FORMAT

DICOM STL Romexis Viewer

CBCT OUTPUT

Cloud & Email
 CD
 USB

EXTRAS

Express Processing Extra copy
 Pathology Report
 Radiology Report

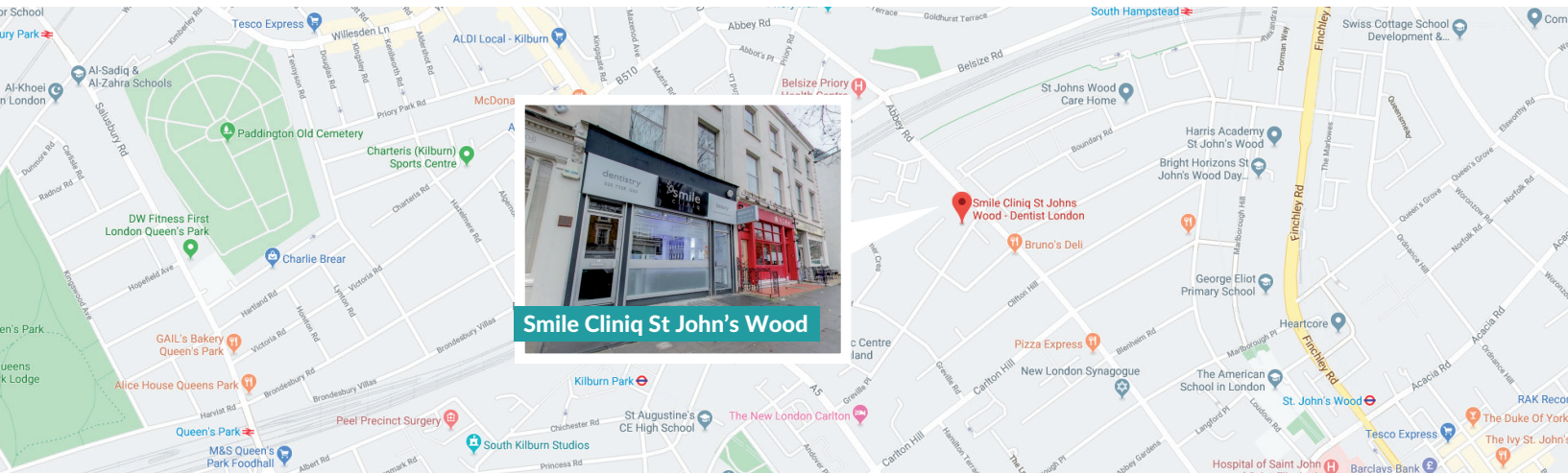
CLINICAL INDICATIONS: (mandatory)

2D IMAGING

Digital Panoramic (OPG)

2D OUTPUT

FTP & Email USB



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