ICE Postgraduate
Dental Institute & Hospital

Prescription for Radiology – ICE Hospital

Form SF1

Patient Details

Name: NHS Number:

Date of Birth: Gender: Male/ Female

Address: Tel Number:
Mobile Number:
Email:

Interpreter Required: Yes/ No If Interpreter required which language……

Ethnic Origin: ……

Pregnancy Status: Not Pregnant/Pregnant If Yes: Gestation weeks: ……

Have you had any X-ray examination in the past 12 months? Yes/ No

Justification

Clinical Context
Result of history, clinical exam or other imaging
What information do you want the exam to provide?

RMH Checked and nothing contra- indicating ☐
Pt Not Pregnant ☐
Pt Consent Achieved ☐

Service specific referral information

Priority: Routine Urgent

Examination Requested including body are to be imaged:
X-ray: CBCT:

Diabetic Status: Allergies:

Relevant Clinical Information
(as examination is protocol based, the quality of the information is important:

Question to be answered:

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Referring Clinician:

Referrer Name: Date of Referral:

GDC/GMC Number: Telephone Number:

Referring practice:

Position:

Is the patient to wear a radiographic template:

Maxilla		£25
Mandible		£25
Both		£40

Area of Interest:

OPT		£65
Mandible 6cm		£90
Maxilla 6cm		£90
Both Jaws 10cm		£160
UL Quad		£65
UR Quad		£65
LL Quad		£65
LR Quad		£65
Small FOV		£60
Indicate Teeth		

Do You Require:

Pathology Report		£75
Radiology Report		£95
3D Model		£350

I agree to the terms and conditions for the prescription of radiographs at the ICE hospital

Signature of referring Clinician _____ Date: _____

For Official Use Only:
Processed by: _____ Radiographer: _____