**Cone Beam CT Scan - Referral Form**

Please complete all sections of the form and return to **bookings.ent@onewelbeck.com**.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT DETAILS** | | | | | | | | | | |
| TITLE: | FORENAME(S): | | | | | SURNAME: | | | |
| MRN: |  | | | | |  | | | |
| DATE OF BIRTH: | | | | | | GENDER:  MALE  FEMALE  OTHER | | | | |
| RESIDENTIAL ADDRESS: | | | | | | POSTCODE: | | | | |
| TELEPHONE: | | | | | | MOBILE: | | | | |
| EMAIL: | | | | | | | | | | |
| **REFERRAL DETAIL** | | | | | | | | | | |
| CBCT – Sinus 20s (600)  CBCT – Sinus 15s (450)  CBCT – Sinus 10s (300)  CBCT – Sinus 10s (150)  CBCT – Temporal Bone 20s (600)  : | | | | | | **EXAM**:  **CLINICAL DETAILS**:  Examinations cannot be performed without enough clinical information (Ionizing Radiation (Medical Exposure) Regulations 2017): | | | | |
|  | |  | | | |
|  | |  | | | |
|  | |  | | | |
|  | | | | | |
| **REFERRER DETAILS** | | | | | | | | | | |
| GP/REFERRER NAME: | | | | | | GP/REFERRER PRACTICE: | | | | |
| GP/REFERRER CONTACT NUMBER: | | | | | | GP/REFERRER EMAIL: | | | | |
| **PAYMENT DETAILS (IF KNOWN)** | | | | | | | | | | |
| TYPE: Self-funding  Insured   Embassy   Other (please complete below sections as appropriate) | | | | | | | | | | |
| INSURANCE COMPANY:  MEMBERSHIP NUMBER: AUTHORISATION CODE: | | | | |  | | | |  | |
| EMBASSY: | | | | | LETTER OF GUARANTEE:  Yes (please attach) | | | | | |
| **EXTRA REQUIREMENTS** | | | | | | | | | | |
| SPECIAL EQUIPMENT REQUIREMENTS: | | | | | | | WHEELCHAIR ACCESS: | | | |
| INTERPRETER REQUIRED:  Yes, please confirm language: | | | | | | |  | | | |
| OTHER: | | | | | | | | | | |
| **DECLARATION** | | | | | | | | | | |
| NAME:  PROFESSIONAL REG/ GMC NO: | | |  | SIGNED: | | | | DATE: | | |

By completing this form, you confirm you have the consent required to share this information.

Please attach the last clinic letter, any relevant test results and any additional documentation to this form & submit to us via one of the following:

E: bookings.ent@onewelbeck.com

A: OneWelbeck, ENT Centre, 1 Welbeck Street London W1G 0AR  
T: +44 (0)203 653 2007 – select option 2