Cone Beam CT: Service Level Agreement

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| For the Referral of Patients for Dental Cone Beam CT Examinations   |  |  |  |  | | --- | --- | --- | --- | | Referring practice | | CBCT practice | | | Address |  | Address |  | | Tel |  | Tel |  | | Email |  | Email |  | | Name of legal person\* |  | Name of legal person\* |  |  |  | | --- | | Referral criteria for dental CBCT | | The document specified here will be used by both parties as the basis for the referral of patients and the justification/authorisation of dental CBCT examination: |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Entitlement of people | | | | | | | Enter below the details of all people at the referring practice who will refer patients for dental CBCT examinations and/or report on dental CBCT images. Evidence of training meeting the requirements of the PHE/BSDMFR Core Curriculum in Dental CBCT must be provided. | | | | | | | For completion by referring practice | | | | For completion by CBCT practice | | | Names | GDC/GMC  Registration number | IRMER17 roles (tick) | | Training OK? | Registration OK? | | Referrer | Operator | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | | Signatures of agreement | | | | | We the undersigned agree: (1) to use the referral criteria above; (2) that evidence of adequate training has been provided for each of the people named above appropriate to their IRMER17 roles; (3) that adequate information will accompany each referred patient to allow the justification process to proceed, as set out in the standard imaging referral form attached. | | | | | For the referring practice | | For completion by CBCT practice | | | Name of legal person\* |  | Name of legal  person\* |  | | Signature |  | Signature |  | | Date |  | Date |  | |

\* The ‘legal person’ is the person/body corporate that takes legal responsibility for implementing the Ionising Radiations Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations 2017 within the practice.