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

This agreement is between:

River Dental Address: *River Dental* *1 Clarendon Terrace* *High Street* *Stockbridge* SO20 6EY Tel: *01264 810818* Email: *kingfisher@river.dental*	**&**	**Referring 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 will make my own arrangement for the reporting of my Cone Beam CT scans acquired at River Dental. This will be done by someone 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 River Dental. 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.will ensure that my training remains up to date.

These guidelines are available on

https://www.gov.uk/government/uploads/system/uploads/attachement_data/file/340159/HPA-CRCE-010_for_website.pdf

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

River Dental Practice	**Referring Clinician**
Signature:	**Signature:**
Date:	**Date:**