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| **Service-Level Agreement for the referral of patients to Richmond Dental Imaging**  **For Dental Cone Beam CT Examinations** | |
| This agreement is between: | |
|  | The Clinician |
| Polar White Ltd T/A Richmond Dental Imaging | Name: |
|  | Address: |
| Tel: 020 8940 3444 |  |
|  |  |
| Email:mail@molars.com | Tel: |
|  | Email: |
|  | GDC No: |
| **Justification:**  I agree to use the referral criteria as per the [European Guidelines: Radiation Protection No. 172](http://www.sedentexct.eu/files/radiation_protection_172.pdf) and provide adequate clinical information in order for each examination to be justified.  **Reporting:**  Please tick one of the following:  I would like my Cone Beam CT to be reported by JM Radiology. The service will be provided by Dr J Makdissi, Consultant in Dental and Maxillofacial Radiology.  I will make my own arrangement for the reporting of my Cone Beam CT scans acquired at Richmond Dental Imaging This will be done by someone adequately trained as per [HPA-CRCE-010- Guidance on the safe use of Dental Cone Beam CT](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340159/HPA-CRCE-010_for_website.pdf)  I will report my Cone Beam CT scans acquired at Richmond Dental Imaging. 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](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340159/HPA-CRCE-010_for_website.pdf). I will ensure that my training remains up to date.  If you need any help filling this agreement please do not hesitate to contact us. | |
| For Richmond Dental Imaging | For the clinician |
| Signature: | Signature: |
| Date: | Date: |