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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: |