DENTAL SCANNING SERVICES

Service Level Agreement

for the referral of patients to Mobile Scanning Service LTD t/a Dental Scanning Services for Dental Cone Beam CT examinations

This agreement is between:

YOUR PRACTICE	THE CLINICIAN
Name:	Name: Signature: GDC Number:
Address:	Address:
Tel:	Tel:
Mobile:	Mobile:
Email:	Email:

This document specified below will be used by both parties as the basis for the referral of patients and the justification / authorisation of dental CBCT examinations

Please tick the appropriate boxes below

☐ **Referral**
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. I have received adequate training as per HPA-CRE-010-Guidance on the safe use of Dental Cone Beam CT (pre 2020), or as per the FGDP-PHE Guidance Notes (2020 onwards). CORE CBCT Level 1 Required

☐ **Justification**
I am acting as the IR(ME)R practitioner and will be justifying my scans. I have received adequate training as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT (pre 2020), or as per the FGDP-PHE Guidance Notes (2020 onwards).

☐ **Reporting**
I would like my Cone Beam CT to be reported on. The service will be provided by a consultant in dental and maxillofacial radiology.

Or

☐ I will make my own arrangement for the reporting of my Cone Beam CT scans. This will be done by someone adequately trained as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT (pre 2020), or as per the FGDP-PHE Guidance Notes (2020 onwards).

Or

☐ I will report on my Cone Beam CT scans acquired from Dental Scanning Services. 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 (pre-2020), or as per the FGDP-PHE Guidance Notes (2020 onwards). I will ensure that my training remains up to date. CORE CBCT Level 2 Required

For the Referring practice
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. Please send a copy of your CORE CBCT Training when returning this Service level Agreement. This is a requirement before any referrals are made.

Name: Signature: GDC Number:		Name: Signature: GDC Number:	
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Name: Signature: GDC Number:		Name: Signature: GDC Number:	

For completion by CBCT Practice

Name:

Signature:

Date: