Service Level Agreement for the Referral of Patients to Crossbank Dental Care for dental Cone Beam CT Examinations

Crossbank Dental Care 10 Captain French Lane Kendal Cumbria LA9 4HP	Address of referring practice:
Tel: 01539 720820	Tel:
Email: info@crossbankdental.com	Email:
Name of legal person: Neil Cooper	Name of legal person*:

Referral criteria for dental CBCT:
The 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:

Name of document: SEDENTEXCT provisional Guidelines V1. 1 May 2009, Chapter 4

Entitlement of Persons
Enter below details of all persons at 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 HPA/BSDMFR Core Curriculum in Dental CBCT must be provided.

For completion by referring practice:				For completion by Crossbank Dental Care:	
Name(s):	**GDC/GMC Reg No.**	**IRMER Roles (tick)**		**Training OK?**	**Registration OK?**
		Referrer	**Operator (reporting)**	P11/P20	

Signatures of agreement:
We the undersigned agree: (1) to use the referral criteria stated above; (2) that evidence of adequate training has been provided for each of the persons names above appropriate to their IRMER roles; (3) that adequate information will accompany each referred patient to allow the justification process to proceed, as set out in our attached Standard Referral Form.

For Crossbank Dental Care:	For the Referring 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 Regulation 1999 and the Ionising Radiation (Medical Exposure) Regulations 2000 within the practice.

TABLE 3 Recommended minimum training requirement for each IRMER dutyholder					
		Dutyholder:			
		Referrer	Practitioner	Operator (imaging)	Operator (reporting)
Initial training	**Theoretical**	3 hours	3 hours	3 hours	3 hours
	Radiological interpretation	See Curriculum	2 hours*	See Curriculum	2 hours*
	Practicals		6 hours	6 hours	6 hours
	Refresher training (as part go Verifiable CPD)	1 hour	1 hour	1 hour	1 hour

Dental Imaging Referral Form for Crossbank Dental Care

Patient Details:
Name:
Address:

Date of birth:

Patient contact telephone numbers: **H:** **W:** **M:**

Referrer details
Name:
Address:
Signature:
Date of referral:
Telephone number:

The Clinical context of requesting a dental CBCT examination

Relevant results of history, clinical examination and other imaging

What information do you want the dental CBC examination to provide?

Define the anatomical area that the scan(s) should cover and tick appropriate box;

- ☐ **one 5x5cm £295**
- ☐ **two 5x5cm, or one 10x5cm £395**
- ☐ **one 8x8cm or additional scans £295**

Justification
Name of IRMER practitioner: Neil Cooper
Signature:
Date:
Details of scan authorised:

Scan information:
Name of Operator: TCO
Signature:
Date of Scan:
Exposure factors used:

Clinical evaluation (Reporting)*
Name of Operator (Reporting):
Signature:
Date:
Outcome:

***If, under the Service Level Agreement dental CBCT images will be reported on by the referring practice, this fact should be recorded here. The referring practice will then be responsible for ensuring the clinical evaluation takes place and is properly recorded.**

ON COMPLETION, RETAIN THIS FORM AND RETURN A COPY TO THE REFERRING PRACTICE. 2018/10