|  |
| --- |
| **Service Level Agreement** **for the referral of patients to YOUR CENTRE for Dental Cone Beam CT examinations** |
| **This agreement is between:** |
| **YOUR CENTRE** | **THE CLINICIAN** |
| **Name:** | **Name:** |
| **Address**: | **Address:** |
| **#Tel:** | **Tel:** |
| **Fax:** | **Fax:** |
| **Email:** | **Email:** |
| **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).***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 by JM Radiology. The service will be

provided by a consultant in dental and maxillofacial radiology.* I will make my own arrangement for the reporting of my Cone Beam CT scans

acquired at YOUR CENTRE. 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).* I will report my Cone Beam CT scans acquired at YOUR CENTRE. 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. |