



Service-Level Agreement for the referral of patients to Shanks Dental Care for
CBCT Examinations.

This agreement is between:

Shanks Dental Care
55 Captain's Road
Edinburgh
EH17 8HP
Tel:
0131 664 2184

Email:
reception@shanksdentalcare.co.uk

Clinician Name:

GDC No:

Address:

.....

.....

Tel:

Email:

I declare that I have received training in CBCT referral and will use CBCT selection criteria, as per current UK guidelines.

Reporting (please tick one of the following)

I will make my own arrangement for the reporting of my Cone Beam CT scans acquired at Shanks Dental Care. This will be done by someone adequately trained as per HPA-CRCE-010-Guidance on the safe use of Dental Cone Beam CT.

I will report my Cone Beam CT scans acquired at Shanks Dental Care. 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. I will ensure that my training remains up to date.

For the Cone Beam CT Centre

Signature:

Date:

For the Clinician

Signature:

Date: