



## Service-Level Agreement for the referral of patients to New Life Teeth for Dental Cone Beam CT Examinations

### This agreement is between:

New Life Teeth  
Canal Point  
22 W Tollcross  
Edinburgh EH3 9QW

Tel: 0131 564 1822  
Email: edinburgh@newlifeteeth.co.uk

Clinician Name: .....  
GDC No: .....  
Address: .....  
.....  
Tel: .....  
Email: .....

### Justification

- 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.

### Reporting

Please tick one of the following:

- I will make my own arrangement for the reporting of my Cone Beam CT scans acquired at New Life Teeth. 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 New Life Teeth. 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.

These guidelines are available on  
[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/340159/HPA-CRCE-010\\_for\\_website.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340159/HPA-CRCE-010_for_website.pdf)

### For the Cone Beam CT Centre

Signature: .....

Date: .....

### For the Clinician

Signature: .....

Date: .....