Service Level Agreement

For the Referral of Patients for Panoramic or Dental Cone Beam CT Examinations

Referring practice		**Receiving practice**	
Name and Address	.... Post Code:	Name and Address	.... Post Code: .....
Tel		Tel	
Email		Email	
Name of employer		Name of employer	

Referral criteria

The documents specified here will be used by both parties as the basis for the referral of patients and the justification/authorisation of dental radiographic examinations:
- Faculty of General Dental Practice (UK) 'Selection Criteria for Dental Radiography', 3rd edition, FGDP (UK), 2013 (updated 2018). https://www.fgdp.org.uk/guidance-standards/selection-criteria-dental-radiography
- Guidelines for the use of radiographs in clinical orthodontics. London: British Orthodontic Society, 2015. https://www.bos.org.uk/Public-Patients/News-Publications/Orthodontic-Radiographs-Guidelines
- Radiation Protection No 172. Cone beam CT for dental and maxillofacial radiology (Evidence-based guidelines). Chapter 4. https://ec.europa.eu/energy/sites/ener/files/documents/172.pdf (**for dental CBCT only**)

Type of radiograph requested	**Please tick as appropriate**
Panoramic	❑
Dental CBCT	❑

Entitlement of people

Enter below the details of all people at the referring practice who will refer patients for Panoramic or dental CBCT examinations and the person(s) who will be reporting on the dental image(s).
Evidence of the training undertaken which meets the requirements of the EADMFR/BSDMFR Core Curriculum in Dental CBCT must be provided for each person acting as referrer and / or operator *(Example: Copy of the CBCT training certificate)*.

For completion by referring practice				For completion by Brighton Implant Clinic	
Name	GDC/ GMC Registration number	IRMER17 roles (tick)		Training OK? (tick if OK)	Registration OK? (tick if OK)
		Referrer	Operator (reporting on images)		
		❑	❑	❑	❑
		❑	❑	❑	❑
		❑	❑	❑	❑

Service level agreement: signatures of agreement

We the undersigned agree: (1) to use the referral criteria above; (2) that evidence of adequate training has been provided for each of the people named above appropriate to their IRMER17 roles; (3) that adequate information will accompany each referred patient to allow the justification process to proceed, (4) that the Referrer will identify a suitably trained person who will report on dental image(s) - Panoramic or the CBCT images, (5) that the referring practice will ensure that the clinical evaluation takes place and is properly recorded.

For the referring practice		For Brighton Implant Clinic	
Name of employer*		Name of employer*	
Signature		Signature	
Date		Date	

* The person who signs here should be the employer or, in the case of a body corporate or other situation where the "employer" may not be available, a suitable representative (eg, a dentist at the practice who is involved with the referrals) who is able to sign on the employer's behalf.