# Service Level Agreement for the referral of Dental CBCT & OPG Examinations

| Referring Practice | ID Reference: | Receiving Practice |
|---|---|---|
| Name: | | Name: BEDFORD DENTAL SURGERY |
| Address: | | Address: 33-35 ST PETER'S STREET<br>BEDFORD<br>MK40 2PN |
| Tel: | | Tel: 01234 269666 |
| Email: | | Email: bedford.stpetersdental@nhs.net |
| Name of Employer: | | Name of Employer: Mr. Riaz Hassan |

## Referral Criteria

The document specified here will be used by both parties as the basis for the referral of patients and the justification/authorization of dental radiographic examinations:

## Entitlement of people

Enter below the details of all people at referring practice who will refer patients for radiographic examinations and/or report on dental images. Evidence of suitable training must be provided.

| For completion by referring practice: | | | | For completion by receiving practice: | |
|---|---|---|---|---|---|
| Names | GDC/GMC Registration number | IRMER 2017 roles (tick) | | Training ok? | Registration ok? |
| | | Referrer | Operator (reporting) | | |
| | | | | | |
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## Signature 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, as set out in the standard imaging referral form attached.

| For the referring practice | | For completion by receiving practice | |
|---|---|---|---|
| Name* | | Name* | Mr Riaz Hassan |
| 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.**