**Service Level Agreement Form For Dental X-ray Examinations**

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| **Service Level Agreement for the Referral of Patients to the Westpoint Dental Center for Dental X-Ray Examinations** | | | | | |
| Address of referring practice:  Tel:  Email:  Name of employer\*: | | | Address of receiving practice:  Tel:  Email:  Name of employer\*: | | |
| **Referral criteria for dental X-ray examinations:**  The document specified below will be used by both parties as the basis for referral criteria for X-ray examinations, as well as justification/authorisation of examinations:  Name of document: *(e.g. referring practice to Westpoint/ operator)* | | | | | |
| **Entitlement of persons**  Enter below details of all persons at referring practice who will refer patients for dental X-ray examinations and/or report on dental X-ray images. Evidence of suitable training must be provided | | | | | |
| For completion by referring practice: | | | | For completion by CBCT practice: | |
| Name | GDC/GMC Reg No. | IR(ME)R roles (tick) | | Training OK? | Registration OK? |
| Referrer | Operator (reporting) |
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| **Signatures of agreement:**  We the undersigned agree: (1) to use the referral criteria stated above; (2) that evidence of training has been provided for each of the persons named above appropriate to their IR(ME)R roles; (3) that adequate information will accompany each referred patient to allow the justification process to proceed, as set out in the attached Standard Referral Form | | | | | |
| For the referring practice:  Name of employer\*:  Signature:  Date: | | | For the receiving practice:  Name of employer\*:  Signature:  Date: | | |
| \* The legal person is the person / corporate body that take legal responsibility for implementing the Ionising Radiations Regulations 2017 and the Ionising Radiation (Medical Exposure) Regulations 2017 within the practice. | | | | | |