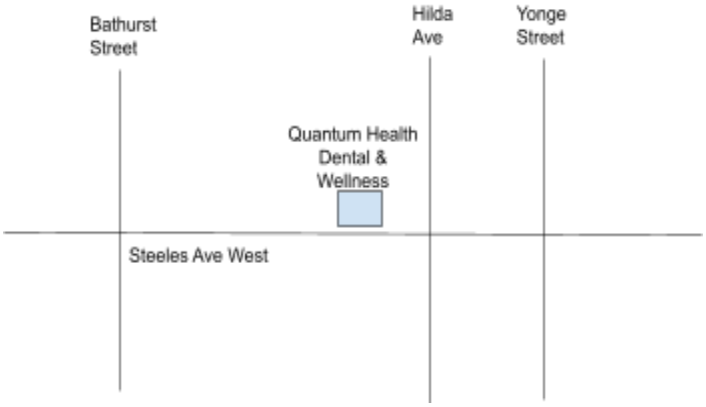
Cone Beam Computed Tomography (CBCT) referral form

QUANTUM HEALTH DENTAL & WELLNESS
398 Steeles Ave W, unit 17-18, Thornhill ON, L4J 6X3
Tel: 905-660-5129 / email:drltreger@rogers.com

Referring dentist Information:
Doctor Name:_____
Practice Name:_____
Address:_____
Phone:_____
Email: _____



Patient Information:
Patient Name:_____
Date of Birth:_____
Phone:_____
email:_____

Region to be Scanned: (please circle)

UR	Upper Ant.	UL
LR	Lower Ant.	LL

Specify tooth number or area: _____

Reason for scan: (please circle)

Implant Site	Sinus	Impaction	Trauma
Surgery	Pathology	Other, please explain:	

Additional comments:_____

Please return completed form
by **fax** 9056608733
or **email** drltreger@rogers.com

Dental CBCT scans will be interpreted by our in-house certified CBCT interpreter. Interpretation with images will be sent to you by email.