

# CBCT REFERRAL FORM

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L1G 0C9



## PATIENT INFORMATION

<b>PATIENT NAME</b>	
<b>PATIENT ADDRESS</b>	
<b>DOB (D/M/Y)</b>	
<b>EMAIL</b>	
<b>TELEPHONE</b>	
<b>DATE SUBMITTED</b>	

<b>REASON FOR REFERRAL</b>	
<b>TOOTH NUMBER</b>	
<b>AREA</b>	
<b>FIELD OF VIEW SIZE</b> <small>(THE FOV MAY BE ADJUSTED BY THE AUTHORIZED CBCT MEMBER BASED ON CLINICAL ASSESSMENT AND ROI NEEDS)</small>	
<b>RESOLUTION</b>	

## REFERRAL GUIDELINES AND INSTRUCTIONS

FORM TO BE COMPLETED BY REFERRING DENTIST

PATIENT REFERRAL FORM TO BE SCANNED AND PLACED INTO PATIENT CHART

PATIENT TO BE NOTIFIED OF FINDINGS

REPORTING AND INFORMATION REGARDING PATIENT INFORMATION TO BE RECORDED IN PATIENT CHART

<b>ADDITIONAL INFORMATION</b>

## COMPLETED SCAN INFORMATION

<b>DATE RECEIVED</b>	
<b>DATE PATIENT CONTACTED</b>	
<b>DATE OF SCHEDULED SCAN</b>	
<b>REPORTING PROVIDED BY</b>	
<b>DATE PATIENT NOTIFIED OF REPORTING INFORMATION (D/M/Y)</b>	
<b>REPORTING INFORMATION ADDED TO PATIENT CHART</b>	
<b>NOTES</b>	

Referring Dentist \_\_\_\_\_ Signature \_\_\_\_\_