CBCT Referral & Requisition Form

SUNCOAST DENTAL

Suncoast Dental
5-397 Bayfield Road
Goderich, ON N7A 4E9

Tel: 226-227-6453
Fax: 226-666-6292
Email: info@suncoastdental.ca

Referring Clinician

Practice Name: _____
Dentist Name: _____
Phone: _____
Email: _____

Patient

Name: _____
Address: _____
Phone: _____
Email: _____
Date of Birth (MM/DD/YY): _____

REMINDER:

Metallic jewellery, partial dentures and hair clips need to be removed for the scan.

CBCT Scan will be billed with dental codes
07011 - Small field of view (e.g. sextant or part of, isolated temporomandibular joint)
07012 - Large field of view (1 arch)
07013 - Large field of view (2 arches)

Cost: $350; urgent reports add $50

CBCT scans are not covered by OHIP or under most medical/dental insurance plans.

Payment is due the day of your CBCT Scan.

Relevant Clinical Details & History

Pertinent patient history, including suspected diagnosis (REQUIRED): _____

_____

_____

_____

Patient medical history: _____

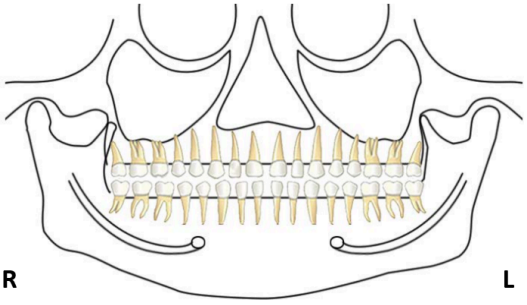
_____

_____

Indication for CBCT Scan

- ○ Implants
- ○ Wisdom Teeth
- ○ Pathology
- ○ Orthodontics
- ○ Sinuses
- ○ Painful/Cracked/Troublesome Teeth (Endodontic)
- ○ Impacted/Delayed/Extra/Malpositioned Teeth
- ○ Other: _____

Circle or Illustrate the Area to be Scanned



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Type of Scan

- ○ Maxillary Full Arch ○ Mandibular Full Arch ○ Small FOV Area: _____
- ○ Dual Scan Technique
- ○ Implant Planning (+ $25) - *evaluate potential implant position, relevant anatomy, bone height/width, etc.*
  - ○ Surgical Guide

Note: _____

Report

Urgency:

○ within 24 hours (+ $50) ○ 15+ days (free)

Delivery:

○ Email (Free) Email Address: _____

Digital File Format:

○ DiCom ○ DCM