





REFERRAL FORM - CBCT

Referring Doctor:	Office:	
Patient:	DOB:	Gender: M / F
Address:		
City:	Postal Code:	
Telephone: (Home) (Ce	ll) Email:	
Consultation is requested for:		
☐ CBCT (Fee: \$350)		
-File Format for CBCT (Default is DICO	M, if unsure choose DICOM): □ DICOM □ DCM	
	any additional email addresses besides the referring office?	
		tos)
	around is approximately 3 weeks): \square No Rush \square 12-17 days (+: \square STAT (+\$150). If rush is needed, date needed by:	
Indication:		
☐ For Implant Planning: Implant Locat	ons:	
9 1	ed 🗆 Measurements Needed (+\$35 per Quad)	
☐ For Surgery:		
	acture $\;\square\;$ Dental Trauma $\;\square\;$ Perforation $\;\square\;$ Resorption $\;\square\;$ Apic	al
Pathosis Canal Anatomy		
☐ For Pathology Assessment: Area:		
9 , 1		
Additional:		
☐ Surgical Guide Fabrication (Fee: \$550 per arch which includes sle	eve for 1 implant, plus \$100 per additional implant in same arch).
☐ Fully Guided ☐ Pilot Hole(s) Only Other:	Implant System: Astra	,.
Implant Tooth#:	Prosthetic Plan:	
Additional Comments:		
Relevant Medical History:		
 Referral Checklist:		
☐ IO Photos & Patient Profile Pic (if	available)	
☐ X-rays - relevant xrays		
☐ Tracker Patient Info – including not	es from the date of the appointment that prompted ref	ferral
☐ Med Hx		
	n patient - and advised that ASSIGNMENT is not	
Patient Initials: Referral Form Completed by:		