Tri-Cities
DENTAL SPECIALISTS

Experience, Excellence.

#201 - 1032 Austin Ave.
Coquitlam, BC V3K 3P3

info@TricitiesDental.ca
(604)939-8467

IMAGING REFERRAL FORM

Referring Doctor Info:

Dr. Name _____ Referring Office Name: _____

Office Address: _____

Office Email: _____ Office Phone:_____

Patient Info:

Name _____ Date of Birth: _____

Address: _____

Email: _____ Phone: _____

Ins Carrier: _____ Group# _____ ID# _____ Policy Holder: _____

Please Select Requests:

Imaging: ☐CBCT ☐Pan **Date Imaging Required: _____**

Area of particular interests:

18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38

Reason: ☐Implant ☐Endo ☐Oral Pathology ☐Other _____

Volume: ☐5x5cm ☐8x8cm ☐11x10cm ☐17x13cm

Area: ☐Mandibular Arch ☐Maxillary Arch ☐Both Arches ☐Sinus ☐TMJ

Specifications: ☐Open ☐Closed ☐Rest/Splint ☐Denture in/out ☐Denture with Radiographic Markers

Send by: ☐Disc ☐USB ☐Courier ☐Pick-up OR ☐Email (3D viewing software req)

Special Instructions/Relevant Clinical History:

_____

_____

_____

_____

Please note, the responsibility of reading the scan is the referring dentists. We are only providing the imaging and not the diagnosis.

Referring Doctor's Signature: _____