Cone Beam CT Imaging Referral Form

Northern Diagnostic Imaging
2009 Long Lake Rd. - Unit 306
Sudbury, ON P3E 6C3
T: 705-523-3355 F: 705-523-5896
info@ndis.ca

Mail, fax or email form

Patient Details

Surname: _____ First Name: _____

D.O.B.: _____ Tel (Home): _____ Tel (Mobile): _____

Address: _____

Reason for Referral

_____

_____

_____

☐ **Forwarding relevant radiographs at time of CBCT request** ☐ **No radiographs available**

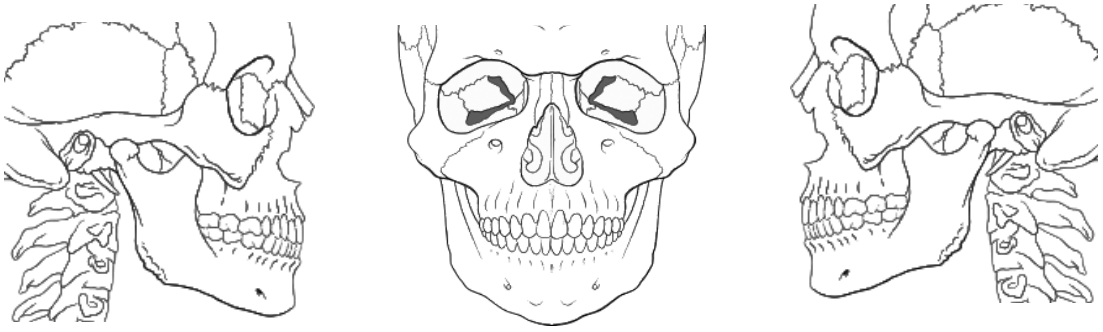
3D Cone Beam Volumetric Imaging

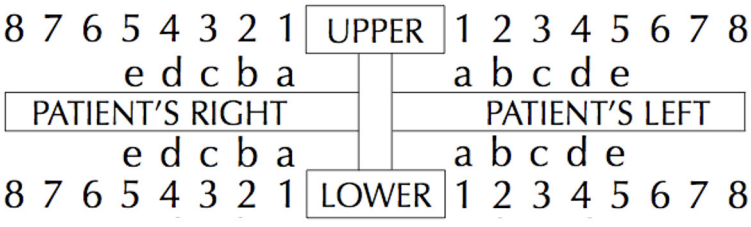
The service includes: Hard copy prints, CD with EZ-3D reader software and report. Please indicate if you also require CD with DICOM files (For NobelGuide™ or Simplant™. Please call to discuss details)

☐ **Implants** ☐ **Dental Impaction** ☐ **Maxillary Sinuses** ☐ **Inferior Alveolar Nerve** ☐ **TMJ Exam***
☐ **Orthodontics*** ☐ **Oral Pathology** ☐ **Endodontics** ☐ **Other**

* Please specify bite: ☐ **Open** ☐ **Maximum Intercuspation** ☐ **Other** (please provide bite registration)

Circle Region of Interest





Conventional Imaging

☐ **Panoramic**

☐ **Cephalometric** (☐ Lateral ☐ Posterior-Anterior) ☐ Carpus

Digital Photography

☐ **Extraoral** ☐ **Intraoral**

Referred by Doctor: _____ Date: _____