

DIAGNOSTIC IMAGING REFERRAL FORM

Please call to book your appointment & be sure to bring this form with you.
Mastercard, Visa, Amex, Debit or Cash accepted as payment.

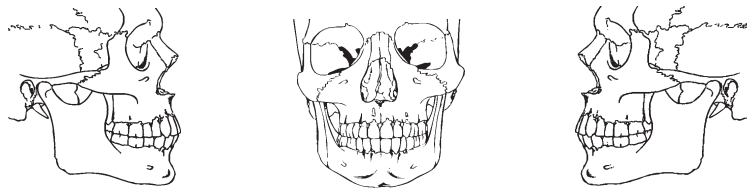
Patient will be charged for services unless otherwise instructed.

Patient's Name: _____ Appt. Date: _____

Date of Birth: _____ Telephone : _____ Appt. Time: _____

3-D Cone Beam Volumetric Tomography (CBVT)

- Single Jaw Both Jaws Full Skull *Please circle Regions of Interest (ROI)*
- Implant/Graft TMJ Impaction/Supernumery Pathology/Trauma Orthodontic
- Sinus Single Site Endo Scan Double Scan Protocol



- Include Radiology Report Radiology Report not required

Other Services

- Panoramic
- Cephalometric Lat PA Carpal Index
- Tracing & Analysis Steiner Jarabak Ricketts Sasouni McNamara
- Other (please specify) _____
- Clinical Digital Photography Standard 8 Views or Specify Quantity of Photos _____

Special instructions / relevant clinical history: _____

Dr. Name: _____ Date: _____

Dr. Signature: _____

- I authorize Orbit Imaging to process and submit insurance claim forms (if eligible) on behalf of the Patient.

Patient Signature: _____

Orbit Imaging Centres

- Vancouver

805 West Broadway, Suite 1001
Vancouver, BC V5Z 1K1
tel: (604) 288-7171
fax: (604) 608-3521

- Richmond

6051 Gilbert Road, Suite 106
Richmond, BC V7C 3V3
tel: (604) 288-7171
fax: (604) 608-3521

*see over for map

Fax completed Referral Form to: (604) 608-3521

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