ORBIT
ADVANCED IMAGING
FOR TEETH, FACE, JAWS & AIRWAY

# DIAGNOSTIC IMAGE REFERRAL FORM

* PATIENT WILL BE CONTACTED DIRECTLY BY ORBIT *

Fax (604-879-9442) or email (info@orbitimaging.com) this completed Referral Form directly to Orbit Imaging

Referral Location: ☐ Vancouver ☐ Richmond ☐ Mobile | ☐ Bill Dr. ☐ Bill Patient Fee: _____

Patient's Name: _____ Appt Date: _____

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

Date Report Required: _____

## 3D Cone Beam Computed Tomography (CBCT)

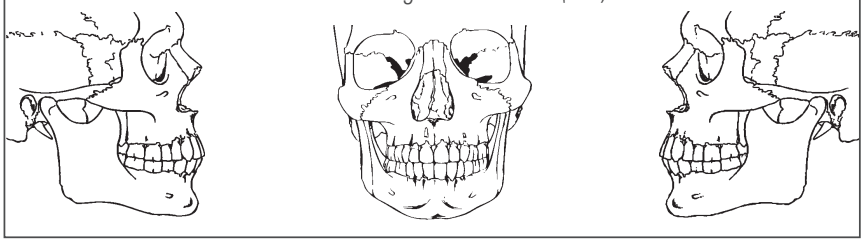
**Field of View**

☐ Single Site (5cm x 5cm) ☐ Single Jaw ☐ Both Jaws ☐ Full Skull ☐ Double Scan Protocol

**Reason for Scan:** _____

☐ Implant(s) / Graft ☐ Guided Surgery ☐ Orthodontic ☐ Sinus / Airway ☐ Endodontic ☐ TMJ ☐ Post Op ☐ Pathology

*Please circle Regions of Interest (ROI)*



**Radiology Report**

☐ Radiology Report Not Required

NOTE: By default, imaging files and reports are uploaded and available through the Orbit HIPAA-Compliant Cloud for one year from patient service.

## 3D Optical Scanning and Guided Surgery Tx Planning

Scan Stone Model: ☐ Max. ☐ Mand.

Scan Wax Up: ☐ Max. ☐ Mand. ☐ Ortho ☐ Implant

Optical Scan Patient: ☐ Max. ☐ Mand.

Implant Tx Planning: ☐ Nobel ☐ Simplant ☐ Other

## Digital Radiography

☐ Pre-Op ☐ Initial ☐ Progress ☐ Final

☐ Panoramic

☐ Cephalometric ☐ Lat ☐ AP ☐ PA

☐ Tracing & Analysis

☐ Carpal Index

## Digital Photography

☐ Digital Photo Series

☐ Orthodontic ☐ Aesthetic

*Specify number of Images:* _____

☐ Digital Duplication of Images

Special instructions / relevant clinical history: _____

Dr. Name: _____ Date: _____

Dr. Signature: _____

Dr. Email Address: _____

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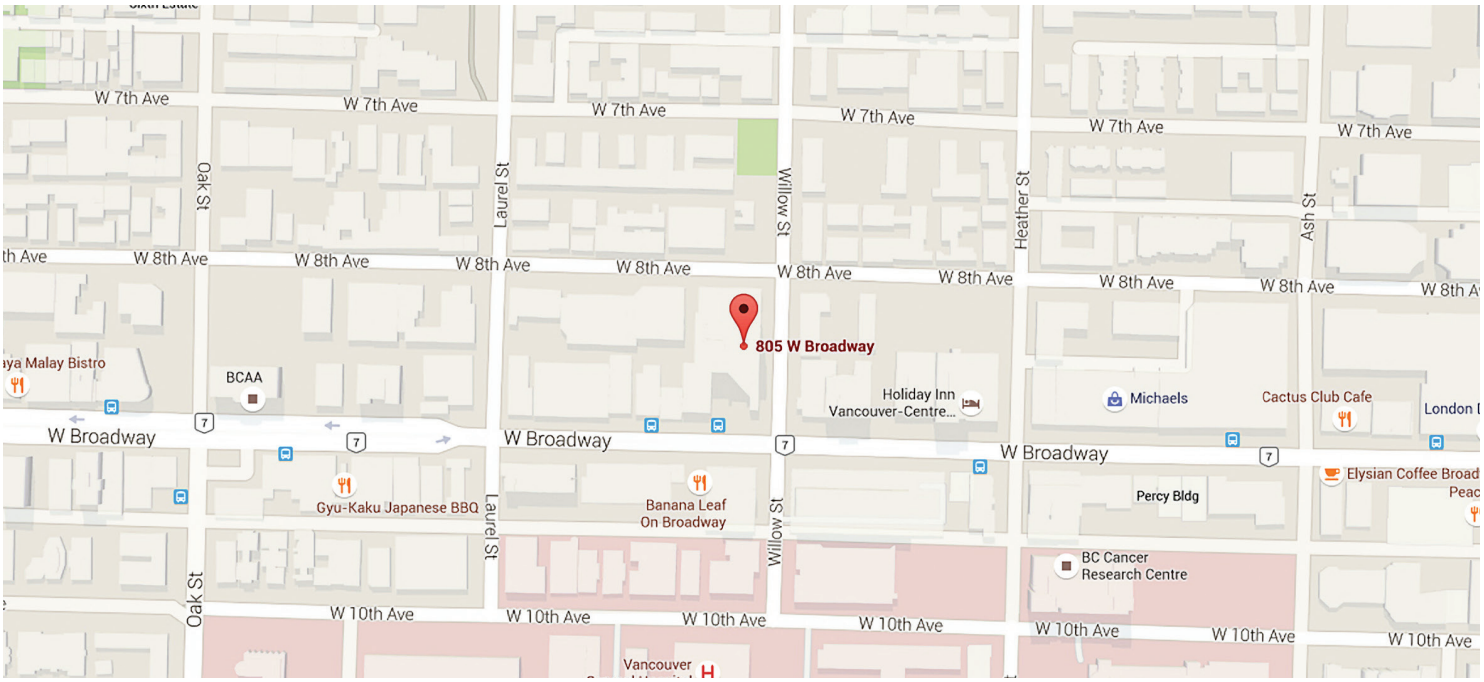
## Orbit Imaging Centres (A division of 0598210 BC Ltd.)

### ☐ Vancouver

805 West Broadway, Suite 500, Vancouver, BC V5Z 1K1 | tel: 604.879.9449 | fax: 604.879.9442




### ☐ Richmond and Orbit Mobile CBCT

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